Baseline descriptive and analytical findings of the GIZ Regional Project for “Crisis Response in Earthquake-Affected Areas” (CREA) in Syria and Türkiye.

BASELINE REPORT

25 June 2026

Dr. Dorothee Weiffen
Sarah Fenzl
Isabella Urbano-Trujilo
Dr. Wolfgang Stojetz
Dr. Ghassan Baliki

Scope and purpose of the baseline report:

The aim of this report is to provide an overview of the baseline landscape and to understand the foundational benchmarks of the broader CREA programme. More specifically, the report provides descriptive findings on the key overarching programme outcome indicators including: access to services, economic situation, mental well-being and social cohesion, and analyse the drivers and interrelationships of these outcomes.

The descriptive and analytical insights presented in this report are derived from data collected across several independent Impact Evaluations (IEs) currently being conducted under the CREA's umbrella in the education, health and livelihood sectors in Syria. For the purposes of this overarching baseline report, these separate datasets have been collated into a single, integrated core database to establish a comprehensive benchmark for the programme.

To maintain a high-level CREA-wide perspective, this report deliberately excludes the granular technical and methodological details specific to each individual evaluation. Therefore, the report does not discuss distinct individual sampling frameworks or designs, nor does it examine the statistical balance between treatment and control groups of the individual IEs. These will be reserved for the final evaluation report.

More detailed information on the impact evaluations being conducted under CREA are available in the inception report, which is attached as an Annex.

Funding Disclaimer:

The regional project CREA of the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH, a federally owned enterprise, implements its objectives in the field of international cooperation for sustainable development on behalf of the German Federal Ministry for Economic Cooperation and Development (BMZ). GIZ CREA has commissioned ISDC - International Security and Development Center to conduct an independent impact evaluation. All opinions and assessments expressed in the inception report are those of the authors.

Acknowledgements:

We would like to thank Bahar Mahzari, Jenny Hornisch, Ina Hammesfahr, Rana Hanbali, Ingo Janssen, Mattes Standke, and Diana Vuzic of the GIZ CREA team for their support. We would also like to thank all colleagues from Eastern Mediterranean Institute, Humanity & Inclusion, Médecins du Monde, Near East Foundation, Orange, Syrian Forum, Violet, and War Child for their invaluable support in conducting the data collection and for their support. We are also grateful to Bayan Hakki, Lina Habbachi, Melodie Al Daccache, Nadra Rabieh and Tilman Brück. We extend our sincere gratitude to all the enumerators for their dedication and immense effort in collecting data, and to all the respondents for generously giving their time to participate in the surveys.

Suggested Citation:

Weiffen, D., Fenzl, S., Urbano-Trujillo, I., Stojetz, W., & Baliki, G. (2026). Baseline descriptive and analytical findings of the GIZ Regional Project for "Crisis Response in Earthquake-Affected Areas" (CREA) in Syria and Türkiye. ISDC - International Security and Development Center, Berlin.

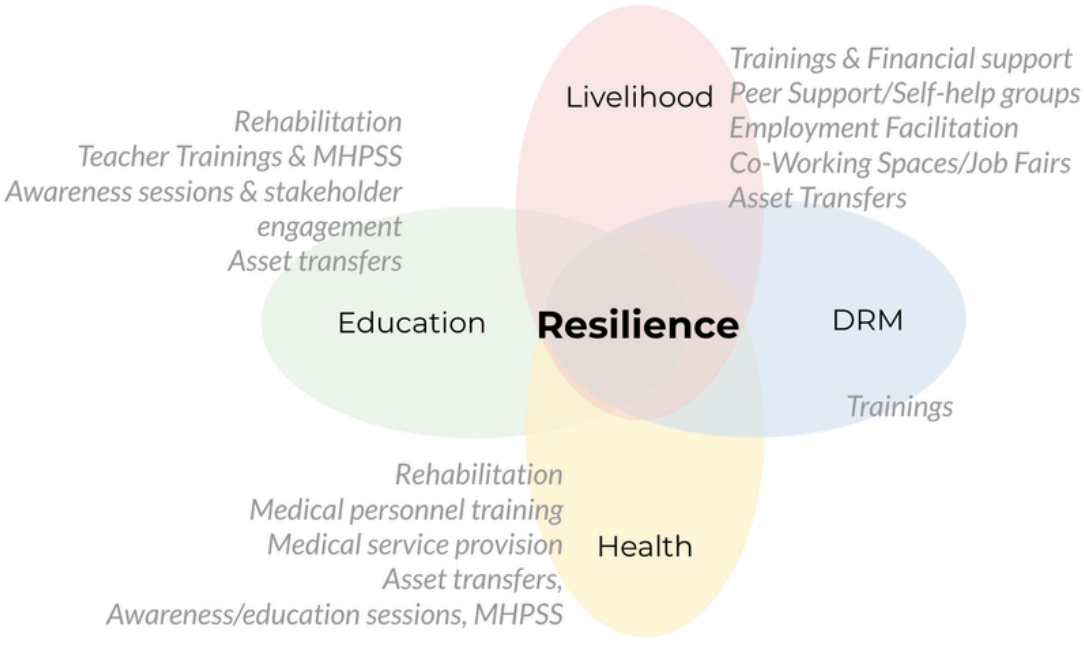
ISDC - International Security and Development Center gGmbH
Welfare Research Program
Gerichtstraße 49, 13347 Berlin,
Germany

Executive summary

Background: In February 2023, parts of Syria and Türkiye experienced two of the worst earthquakes in recent history, causing widespread destruction to infrastructure and directly affecting the lives and livelihoods of more than 15 million people. In northwest Syria, the impacts of the earthquake were particularly severe, exacerbating existing fragility after years of armed conflict in the region. The earthquake increased household vulnerability and reduced their capacity to cope with shocks, with marginalized groups and women being disproportionately affected.

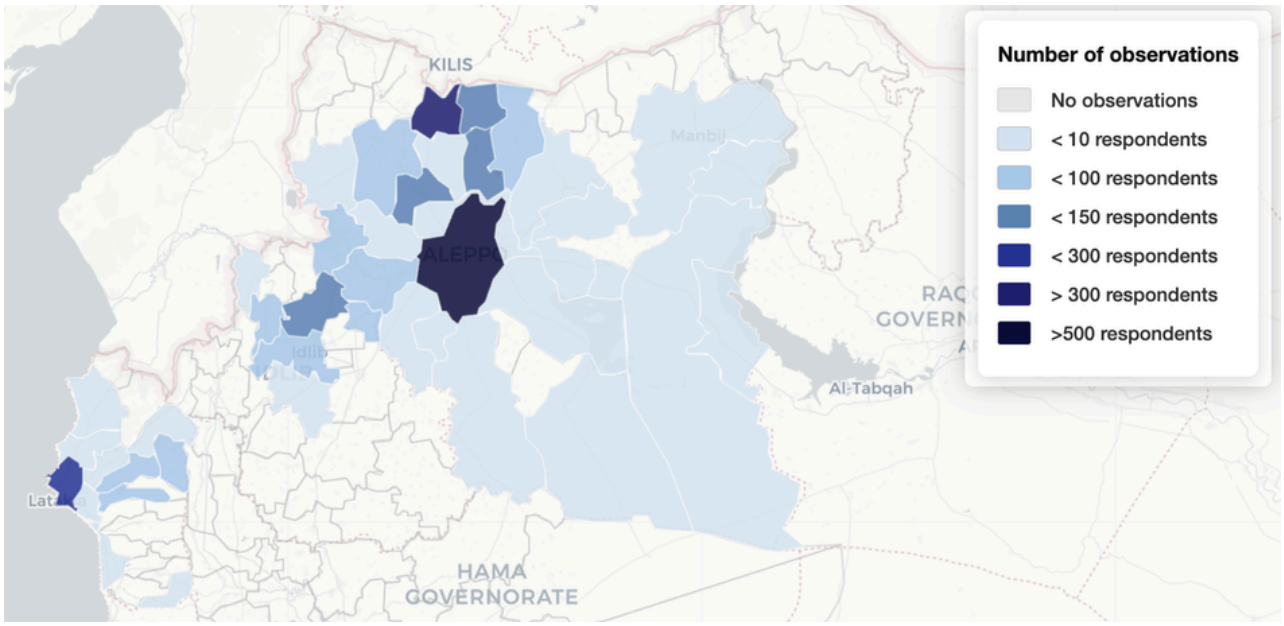
Program objectives and activities: Against this backdrop, the regional project "Crisis Response in Earthquake-Affected Areas in Syria and Türkiye" (CREA), implemented by the German Agency for International Cooperation (GIZ) and commissioned by the German Federal Ministry for Economic Cooperation and Development (BMZ) provides holistic multisectoral support to strengthen the resilience of the population residing in earthquake-affected areas to better respond to future shocks, with a particular focus on women and girls.

CREA focuses on four key sectors: education, health, livelihoods, and disaster risk reduction/management (DRR/DRM). In the education sector, teachers receive integrated training on pedagogical skills, including modern and trauma-sensitive teaching methods, alongside structured psychosocial support. Furthermore, five schools will benefit from rehabilitation activities. In the livelihood sector, the interventions include village savings and loan associations (VSLA), digital bootcamps and microcredits distribution. The interventions in the health sector focus on building capacity, infrastructure and clinic rehabilitation, service mapping and direct medical service provision especially for People with Disabilities (PwD). Finally, DRR/DRM interventions include the delivery of inclusive training sessions to strengthen community-based disaster response. While the interventions in each sector individually contribute to strengthening the resilience of individuals and households, it is the overlap of these activities that is expected to amplify community-level resilience by creating synergies to address interconnected needs of the targeted population.



Impact evaluation: ISDC - International Security and Development Center (ISDC) is conducting a rigorous impact evaluation of the overall CREA multi-sectoral program and the distinct interventions in the education, health and livelihoods sectors in Syria. The evaluation aims to estimate the impact of the CREA activities on the following household and individual outcomes: access, utilization and satisfaction of health and education services; socioeconomic situation and income generation; mental well-being and life satisfaction; social cohesion, trust and networks; and resilience to shocks.

Baseline data and sample composition: To establish a pre-intervention benchmark for the impact evaluation, micro-level baseline data were collected in collaboration with the implementing partners from 3,101 respondents across most CREA interventions between September 2025 and May 2026. The sample includes 1,138 female adolescent students who completed a short self-administered questionnaire and a drawing task to assess their socio-emotional wellbeing, and 1,963 adult respondents who were surveyed using the full questionnaire covering the key outcome indicators (which form the core database).



	Female respondent	Female headed household	Household head completed tertiary education	Households have members with disability	Reside in urban area	Internally displaced households	Affected by the 2023 earthquake
Overall	79%	32%	34%	39%	60%	21%	77%
Education	87%	25%	74%	19%	63%	7%	72%
Health	61%	12%	13%	65%	42%	11%	73%
Livelihoods	86%	48%	24%	34%	70%	35%	82%

The map shows the geographic coverage of the core database sample, which includes a diverse profile of respondents: teachers from the education sector in Aleppo, Idleb and Lattakia; applicants and program participants from the livelihoods sector in Aleppo and Lattakia; and patients and healthcare service beneficiaries in the health sector from Aleppo and Idleb.

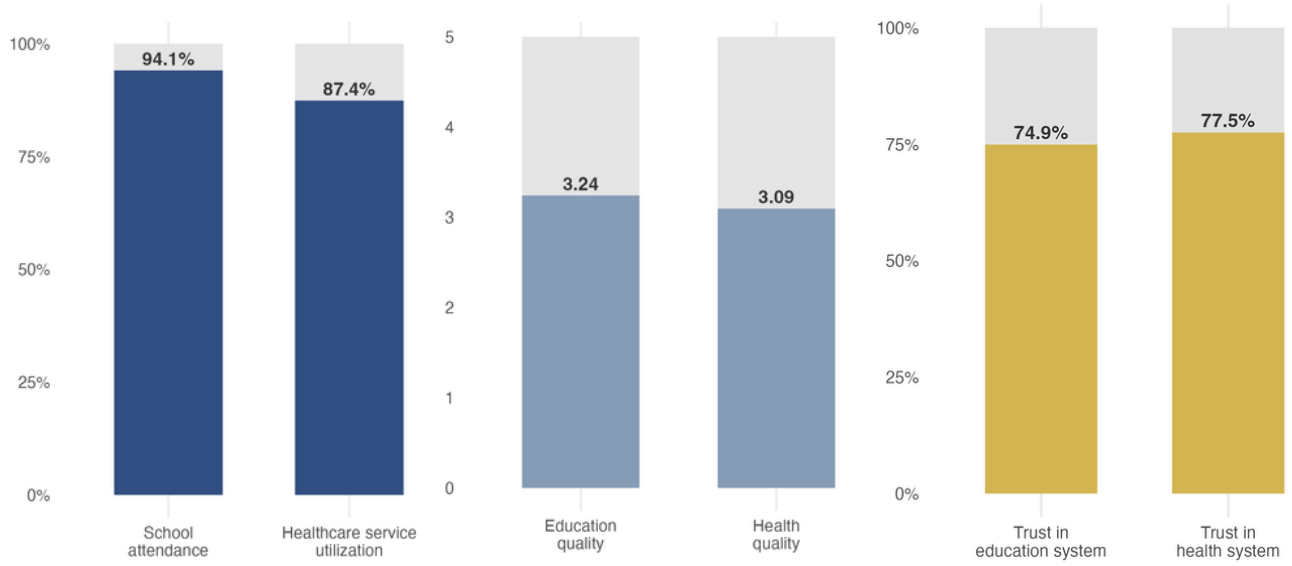
Overall, the majority of households reside in Aleppo governorate and third are headed by a woman. Around 2 in 5 households have a member with disability and 1 in 5 households are internally displaced. A smaller share, 6%, are returnee households. 60% of households reside in urban areas and 77% were directly affected by the 2023 earthquakes, experiencing shelter damage (24%), service disruption (23%), and direct income loss (17%). The profile of households vary by sector, where for example, households from the health sector have larger share of male-headed households, lower tertiary education levels, more members with disabilities and more likely to reside in rural areas compared to households from the livelihoods and education sectors. On the other hand, around 1 in 2 respondents from the livelihoods sector live in a female-headed household and almost all respondents from the education sector have completed a tertiary education. These diverse profiles of the sample reflect the targeting and inclusion criteria of the program interventions and will be crucial for interpreting the findings.

Key Baseline Findings

The baseline findings present descriptive and analytical insights into the situation of the households in targeted CREA areas before the start of the interventions. In addition to providing a snapshot to capture access to services, socioeconomic and mental wellbeing, and trust and social cohesion, the analysis also explores how these outcomes correlate to lay the groundwork to tracking the impacts. The findings can be summarised as follows:

Access and quality of education and health services: access and utilization of education and healthcare services is relatively high at baseline, with school attendance among enrolled children at 94% and the use of healthcare services when needed at 87%. Respondents with disabilities report a significant accessibility deficit for general health services, highlighting additional barriers this group faces. For the education sector, overall satisfaction with quality is the strongest predictor of regular attendance. Prevalence of school challenges, such as teacher absence, lack of materials, and inadequate facilities, are strongly associated with lower quality ratings, and quality ratings in turn are closely linked to trust in education systems. In the health sector, perceived accessibility, functionality, affordability and consultation time are positively associated with access and utilization, and quality perceptions are similarly linked to institutional trust in healthcare systems. Direct contact with medical personnel, particularly sufficient consultation time, emerges as the most important predictor of trust. Addressing structural deficiencies can therefore be a direct pathway to improving both satisfaction and trust in these services and systems.

Economic wellbeing: The economic landscape is characterized by notable financial constraints. Average monthly household income stands at 2.3 million SYP, just above the minimum expenditure basket of 2.2 million SYP. Moreover, income diversification is low, where the majority of households rely on one income source.



Households with members of disability are among the most economically vulnerable, earning on average about 0.30 million SYP less per month than those without.

Only 24% of the livelihood respondents have access to formal or informal financial services, which is heavily gendered. 17% of female respondents have access to financial services compared to 72% of male respondents. While financial inclusion and access to financial services is associated with higher household income for women, it does not close the individual earnings gap. Women earn substantially less than men, and this disparity persists regardless of financial access, pointing to other potential structural barriers, such as market access and social norms.

Mental wellbeing: Psychological distress is pervasive across the sample, with 64% of respondents having signs of depressive symptoms. Rates are highest among health respondents (78%) and livelihoods respondents (68%). Earthquake exposure is the strongest predictor of the prevalence of depressive symptoms: households who were directly impacted by the earthquake score substantially higher on the depressive symptom scale.

In the education sector, we identify a transmission pathway between teacher and student mental well-being. On average, students in schools where teachers exhibit above the clinical cut-off for depressive symptoms have higher levels of depressive and anxiety symptoms than those in schools below the threshold. On the other hand, schools with higher average teacher positive reciprocity (those who are willing to return a favor if they received one) show significantly lower symptoms among students. Moreover, teachers who use personal stress management strategies have on average substantially lower prevalence of depressive symptoms. Taken together, these findings suggest that improving teachers' psychosocial wellbeing may generate meaningful downstream benefits for students, reinforcing CREA's logic and intervention pathways.

Social cohesion: Earthquake-affected households report significantly stronger social network connections than unaffected households, suggesting that the exposure to this severe shock might have activated or reinforced awareness of informal support systems.

Trust in education and healthcare institutions remains strong despite low service quality ratings: 75% and 78% of respondents trust the education and healthcare systems, respectively,

exceeding trust levels in neighbors and the broader community. This points to resilient institutional anchors in Syria of the education and healthcare systems that persist independently of satisfaction in the quality of their services.

Conclusions and lessons learned

In summary, the baseline findings highlight the widespread structural vulnerability facing communities, particularly women, in northwest Syria. A large share of the respondents were directly affected by the 2023 earthquakes, compounding years of distress and fragility from armed conflict, where the burden of psychosocial distress remains pervasively high. Households live on an average monthly income of 2.3 million SYP, just above the subsistence threshold, with limited income diversification. Moreover, supply-side deficiencies in education and healthcare services remain prevalent and satisfaction in the quality of these services is just slightly above average. Despite these conditions, access to and trust in education and healthcare systems remains relatively intact, establishing a strong basis to building resilience within these communities. Based on these findings, we draw five key lessons.

Lesson 1 — Supply-side deficiencies undermine satisfaction and trust.

In both the education and health sectors, specific deficiencies, such as teacher absence, lack of school materials, poor hygiene facilities, and insufficient medical consultation time, are strongly associated with lower satisfaction and trust. Households with disabled members report consistently lower trust across both sectors. Addressing these service delivery gaps is likely to yield improvements in quality ratings, utilization, and trust simultaneously.

Lesson 2 — Intersectionality shapes service accessibility

Accessibility challenges in the health sector are not uniform. Male respondents with disabilities report higher accessibility deficits for general health services, while households with disabled members consistently report lower income and lower trust across both sectors. Interventions tailored to the intersection of gender and disability are likely better positioned to ensure equitable service delivery.

Lesson 3 — Structural barriers to women's earnings persist beyond financial inclusion

Access to financial services is associated with higher household income for women but does not close the individual gender earnings gap. Livelihood programming could go beyond capital provision to address structural barriers such as market access and social norms that constrain women's individual economic returns.

Lesson 4 — Psychosocial wellbeing is a cross-cutting program multiplier

Schools where teachers report higher distress also report higher student depressive symptoms, pointing to a direct transmission pathway. Teachers who use personal stress management strategies report significantly lower depressive symptom scores, validating the MHPSS-centered approach in CREA's teacher training. Integrating psychosocial support as a cross-cutting foundation, rather than a sector-specific add-on, has the potential to strengthen program outcomes across all sectors.

Lesson 5 — Crises activate social networks that can underpin long-term resilience

Earthquake-affected households report stronger informal support networks than unaffected households, and this effect appears to persist more than two years after the shock. CREA's activities that engage and formalize these networks, including VSLAs, peer learning groups, and teacher-parent associations, are well-placed to sustain community resilience beyond the immediate crisis response period.

Table of contents

List of figures and tables

List of abbreviations

BMZ	German Federal Ministry for Economic Cooperation and Development
CES-D-10	Center for Epidemiologic Studies Depression Scale (10-item)
CI	Confidence Interval
CORE	Coaching, Observing, Reflecting and Engaging
CREA	Crisis Response in Earthquake-Affected Areas
CSO	Civil Society Organizations
DRM	Disaster Risk Management
DRR	Disaster Risk Reduction
EMI	Eastern Mediterranean Institute
GDPR	General Data Protection Regulation
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH
HI	Humanity and Inclusion
HH	Household
HHH	Household Head
IDP	Internally Displaced Person
IE	Impact Evaluation
ISDC	International Security and Development Center
LOESS	Locally Estimated Scatterplot Smoothing
MdM	Médecins du Monde France
MHPSS	Mental Health and Psychosocial Support
MMAP	Measuring Mental Health among Adolescents and Young People
NEF	Near East Foundation
OLS	Ordinary Least Squares
PCA	Principal Component Analysis
PFA	Psychological First Aid
PHCC	Primary Health Care Center
PTA	Parent-Teacher Associations
PwD	People with Disabilities
SF	Syrian Forum
SYP	Syrian Pound
TVET	Technical and Vocational Education and Training
VSLA	Village Savings and Loan Association

1 Introduction

1.1 Background

In February 2023, parts of Syria and Türkiye experienced one of the most destructive sequences of earthquakes in recent history, causing widespread destruction to infrastructure and directly affecting the lives and livelihoods of more than 15 million people. In Syria, an estimated 6.6 million people were residing in high-intensity areas impacted by the earthquakes, mainly in the governorates of Aleppo, Idleb and Lattakia.[1] Physical damage and economic loss were estimated at US$3.7 billion and US$1.5 billion, respectively.[1] Earthquake-related displacement added to the already staggering 3 million people internally displaced by conflict within these same regions.[2] As many households were already facing significant vulnerabilities before the disaster, their ability to cope was severely limited, increasing the likelihood of long-term negative welfare impacts.

In Syria, the limited institutional capacity and political fragmentation during this time period limited the adequate humanitarian response and exacerbated the delivery of aid across both regime- and opposition-held areas.[2] While the housing sector experienced the largest share of physical damages, losses were approximated to be $300 million in the health sector and $116 million in the education sector.[2] In Aleppo and Idleb, up to 10% of the education facilities were damaged or destroyed.[2] Additionally, impacts of disaster are never gender neutral, and affect women, people with disabilities, and children disproportionately.[2] Therefore, the impacts of the earthquakes exacerbated existing fragility from the conflict in the Northwest of the country, further increased household vulnerability, and reduced their capacity to cope with shocks, with marginalized groups and women being disproportionately affected.

1.2 The CREA program

Against this backdrop, the regional project "*Crisis Response in Earthquake-Affected Areas in Syria and Türkiye*" (CREA), operated by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH and commissioned by the German Federal Ministry for Economic Cooperation and Development (BMZ), provides holistic multisectoral support to strengthen the resilience of the population residing in the earthquake-affected areas to

[1] Aoun, Joy-Fares; Parvez, Ayaz. Syria Earthquake 2023 - Rapid Damage and Needs Assessment (RDNA) (English). Washington, D.C. : World Bank Group.
http://documents.worldbank.org/curated/en/099093003162314369

[2] See report by Niklas Sense, February 2024: Gender Analysis for the regional project "Crisis Response in Earthquake-affected Areas in Syria and Turkey" (CREA)

better respond to future shocks, with a particular focus on women and girls. CREA focuses on four key sectors: *education*, *health*, *livelihood*, and *disaster risk reduction/management* (DRR/DRM). While the interventions in each sector individually contribute to strengthening the resilience of individuals and households, it is the overlap of these interventions that is expected to amplify community-level resilience by addressing interconnected needs spanning basic services, economic opportunity, psychosocial well-being, and disaster preparedness.

The *education* interventions aim to strengthen the resilience of education services in areas severely affected by the 2023 earthquakes, combining school infrastructure rehabilitation with integrated teacher training and psychosocial support. Specifically, teachers receive training in pedagogical skills, modern teaching methods, psychological first aid, and trauma-sensitive classroom practices, supported by individual mentoring, peer learning circles, and self-care planning. Moreover, five schools will undergo comprehensive rehabilitation focused on improving overall safety, adequate classroom space, ventilation and natural light, sanitation, reliable electricity, and specialized learning facilities. This will be accompanied by a participatory planning process with the school community. The interventions further promote community engagement through parent-teacher associations, leadership workshops for female teachers, and gender equity awareness sessions, with a particular focus on empowering female educators. Overall, these interventions aim to create more inclusive and nurturing learning environments that improve students' engagement, mental well-being, and educational outcomes.

The *livelihood* interventions are designed to enhance economic opportunities and financial inclusion for earthquake-affected households, with a strong focus on female-headed and other vulnerable groups. Activities include the provision of vocational and skills training, financial support, productive asset transfers, job fairs, co-working spaces, and the formation of peer support and self-help groups, all aimed at removing structural barriers to economic participation. Implementing partners offer tailored interventions ranging from village savings and loan associations to digital bootcamps, with priority given to women and those with lower incomes or proximity to implementation sites, aiming to support them in starting or growing small businesses, securing sustainable livelihoods, and strengthening broader community resilience.

The *health* interventions aim to improve equity, access, and quality of health services by combining infrastructure rehabilitation, capacity building, service mapping, and direct medical service provision. Health care centers will be rehabilitated and equipped, health staff and community health volunteers will receive capacity development, and services will span physical rehabilitation, prosthetics, mental health and psychosocial support,

immunization, nutrition, and sexual and reproductive health, with a strong focus on people with disabilities, women, girls, and other marginalized populations. Referral pathways and outreach activities will further extend the reach of these services to communities with limited access. Overall, these interventions aim to improve health outcomes for vulnerable populations and contribute to long-term system resilience and sustained improvements in quality of life.

The *DRR/DRM* interventions will focus on improving the preparedness and local capacity of communities to respond to future shocks. They aim to deliver inclusive training sessions, especially targeting women and girls, to strengthen community-based disaster preparedness. These interventions are aligned with the assumption that organizational and individual capacities, especially of women-led CSOs,women's groups and service providers from both Syria and Türkiye, are empowered through inclusive crisis response training. Detailed information on all of the interventions can be found in Appendix A1.

1.3 The impact evaluation

To generate robust evidence on the impact of these interventions, GIZ is collaborating with ISDC to conduct an impact evaluation of CREA. The assessment aims to estimate the impacts of the *education*, *health*, and *livelihoods* interventions; to evaluate the effectiveness of the multisectoral approach; and to place particular emphasis on marginalized groups, including women, girls, and people with disabilities. It will assess the distinct impacts of CREA interventions on households' economic situation, their well-being, access to services, and their resilience during recovery from a severe adverse shock. Further, the assessment will generate actionable recommendations for stakeholders, including relevant Syrian and German ministries, strengthen local capacity for evidence generation, and contribute to the global knowledge base on resilience interventions in crisis settings.

To evaluate CREA's multisectoral and multi-partner framework, the impact assessment utilizes a two-pronged approach, as detailed in the project's Inception Report.[3] First, it examines the distinct, short-term impacts of the interventions within the *education*, *health*, and *livelihoods* sectors using tailored, quasi-experimental designs that compare service recipients against localized comparison groups. Second, it consolidates primary household-level data across all three sectors into a single database using a shared set of core indicators. While the individual sector evaluations offer maximum rigor, this integrated program-level dataset provides the multi-dimensional framework necessary to

[3] More details on the overall as well as the sector-specific impact evaluation designs are described in the Inception report.

track how household welfare, vulnerability, and resilience evolve across overlapping areas of support over time.

2 Scope, data and approach

2.1 Scope and aim of the baseline report

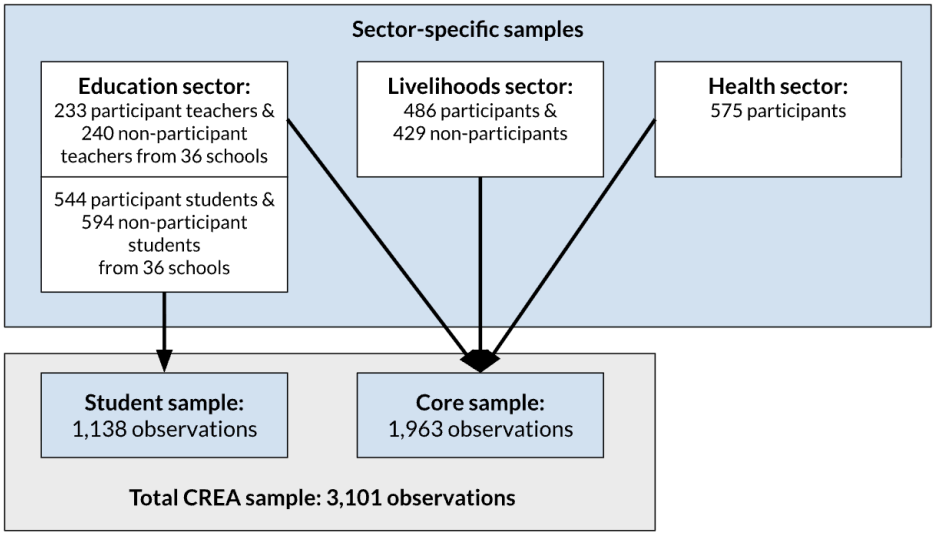
This baseline report presents descriptive and analytical insights on the situation of populations targeted by the CREA program before the start of interventions. Drawing on baseline survey data collected across the *education*, *livelihoods*, and *health* programs in Syria, the report provides a situational snapshot of the CREA-targeted communities, capturing their socioeconomic conditions, well-being, access to services, and exposure to shocks. Beyond describing the baseline context, the report examines how key indicators relate to one another and identifies key correlates of these outcomes. Sector-specific insights are captured through targeted 'Spotlights' integrated throughout the report to provide deeper insights into the distinct components relevant to each intervention. Together, these analyses establish the pre-intervention benchmark against which sector-level and program-level impacts will be assessed, and lay the groundwork to track how household welfare, vulnerability and resilience evolve.

2.2 Baseline data and key outcome indicators

To establish a reference point for the impact assessment, we collected micro-level baseline data from respondents across all three CREA sectors, reaching a total of 3,101 survey respondents. The sample composition differs by sector and partners, reflecting the distinct inclusion criteria of participants and the variety of intervention modalities. In the *education* sector, teachers from girls' (and mixed) schools across Aleppo, Idleb, and Lattakia were surveyed. In the *livelihoods* sector, we surveyed program applicants in Aleppo and Lattakia. In the *health* sector, we surveyed patients immediately before receiving support at health facilities in Aleppo and Idleb. Together, this data forms the *core database* (see Figure 1).[4] The data also includes observations from teachers and *livelihood* applicants who will not receive direct support from the program, but are surveyed as a comparison group of the individual impact evaluations.

[4] More information on the sample selection, the study design for the impact assessment and the methods that will be applied is provided in the inception report.

Figure 1. Composition of the data by CREA sector



All surveys, regardless of sector and type of intervention, share a common *core* questionnaire and set of CREA-level indicators covering key dimensions of household welfare. These include access to and quality of education and health services, access to basic services and assets, household income and expenditure, use of coping strategies, social cohesion (social networks and trust), mental well-being (symptoms of depression and life satisfaction), and exposure to shocks, including the 2023 earthquakes (all survey measures are covered in Appendix A2). In this report, we focus on a set of key outcome indicators, as presented in Table 1. In addition to this core module, each sector-specific survey includes additional modules designed to capture outcomes that are relevant to the respective interventions. These included, for example: teaching practices and classroom environment in the *education* sector; financial literacy and business management in the *livelihoods* sector; and health service access and functional limitations in the *health* sector (see Appendix Table A2).

Table 1. Description of key outcome indicators

Access and quality of services	Access to education services	School attendance of enrolled children
	Quality of education services	Problems experienced by the respondent's child at school; Rating of education quality regarding functionality, classroom environment, and overall satisfaction with quality of education at their child's school
	Access to health services	Utilization of medical services; *Health only: Accessibility of general and specialized health services*
	Quality of health services	Rating of health service quality regarding accessibility, affordability, functionality, and time spent during consultation
Economic situation	Income	Monthly household income; monthly respondent income in Syrian pounds in millions
	Income sources	Number of household income sources
Mental well-being	Depressive symptoms	Depressive symptoms based on the respondents' self-reported feelings
Social cohesion	Social networks	Access to informal help and support systems outside the household
	Trust	Trust in local networks and service providers

Baseline data collection took place at different stages between September 2025 and May 2026 (see Figure A2 in the Appendix for a timetable of the data collection period). Surveys were conducted by local enumerators of the implementing partner organizations, primarily through face-to-face interviews, with a subset of respondents interviewed via phone. Each survey took approximately 45 minutes to complete. Prior to data collection, we held remote training sessions for all enumerators, conducted in Arabic, covering the survey tools, data quality standards, procedures for handling sensitive topics, and ethical considerations. All participants provided informed consent before data collection, with written caregiver consent obtained for students under 18 years. The study adheres to strict ethical standards, including secure handling of personally identifiable information,[5]

[5] To ensure the highest standards of scientific and ethical practice are adhered when doing so, ISDC has adopted these "Ethical Principles for Collecting Primary Data and Conducting Fieldwork" (henceforth "Ethical Principles"). The Ethical Principles complement ISDC's "Code of Conduct", its "Guideline for

gender-balanced enumerator teams, and established referral pathways to psychosocial support services for *education* sector participants.[6]

Additionally, as part of the IE of the *education* sector, we collected paper-based assessments from 1,138 students across all participating and non-participating schools. Each student completed a short self-administered questionnaire, assessing their socio-emotional and mental well-being, including emotional competence, belief-in-self, and symptoms of depression and anxiety.[7] The student assessment took approximately 30 minutes to complete and is not part of the *core database*. An overview of the data composition is shown above, in Figure 1.

2.3 Analytical approach

We use the integrated *core database* to map the initial conditions of participants and provide the benchmarks needed to answer the program's overarching learning questions (O.1 to O.5)[8]. Specifically, we explore how households are currently responding to severe shocks (O.1) and map the baseline levels of household access to and quality of health and education services, economic situation, mental well-being, and social cohesion (O.2).

To do this, we use a stepwise analytical approach to uncover the underlying correlates of household access to and quality of education and health services, economic situation, mental well-being, and social cohesion. We test whether key findings hold even when we account for differences in individual profiles (such as age, gender, and marital status), household characteristics (such as household size, household head gender and education, household income, and having a household member with a disability), and varying exposure to shocks (including displacement status and earthquake experience). The full analytical model accounts for all differences at the same time.

Ensuring Good Scientific Practice" and its "Data Protection Policy". ISDC will not engage in research violating its Ethical Principles. The Ethical Principles are binding for all staff and sub-contractors of ISDC, and we strictly follow these practices and guidelines. We comply with strict GDPR regulations in obtaining, storing and processing personal data.

[6] Additionally, ethical approval for the *education* impact evaluation was granted by the Health Media Lab Institutional Review Board on 7 November 2025.

[7] Alongside, the students completed a drawing task, which indirectly measures the same outcomes as the questionnaire. The drawing data is not part of this baseline report.

[8] The overall learning questions were specified in the Inception report: O.1 How do individuals, households and communities in earthquake-affected areas in Syria respond to crises and shocks?; O.2 How do the economic situation, well-being, access to services, and resilience evolve during the recovery phase of a severe adverse shock (earthquake)?; O.3 Does the overall CREA multisectoral approach improve beneficiaries' economic situation, well-being, access to services, and resilience in the short-term?; O.4 What are the sectoral-level mechanisms underpinning these impacts?; O.5 How do these impacts vary by gender, displacement status and exposure to shocks?

Moreover, to ensure that the findings are robust and not driven by partner-specific factors, we always control for differences related to the specific operational setups of the CREA implementing partners.[9] Ultimately, this approach helps ensure that the observed patterns accurately reflect the diverse experiences of the participants and are not driven by structural differences in the partners and the interventions.

Throughout Section 4, we use coefficient plots to visually display our key analytical findings. These figures show the magnitude and direction of a relationship based on the full model specification. Each point on the plot represents our best estimate of that relationship, while the lines extending from the point (the 90% confidence intervals) show the margin of certainty around that estimate. Unless otherwise noted, each estimate is derived from a separate linear regression model.

3 Baseline descriptive findings

3.1 Household and respondent profile

To describe the overall household and respondent profiles, we first show the baseline characteristics of the *core database*, covering the entire CREA study sample, at the overall level and disaggregated by CREA sector (Table 2). In this sample, women make up the vast majority of the surveyed population, though this share varies significantly by sector. Women account for 87% of teachers in the *education* sample and 89% of program participants and non-participants in the *livelihoods* sample, which clearly reflects the study's inclusion criteria of girls' schools in the CREA *education* sector and the priority given to women in the CREA *livelihoods* sector. By contrast, the *health* sample captures a more balanced demographic, with men representing nearly 40% of the respondents.

There is pronounced variation in the educational attainment of respondents: teachers are almost exclusively tertiary-educated (98%), while 79% of *health* patients have primary education or no formal education.[10] In the livelihoods sample, 30% of respondents have tertiary education, while 57% have none or only primary education, reflecting the heterogeneity of the targeted groups within that subsample.

[9] Due to the unique structure of the education data, the student-level analysis follows a slightly modified sequential process. We first review student summary statistics independently, and then analyze student outcomes jointly with school-level teacher averages. This step applies a similar sequential approach, adjusting first for partner-specific differences and then for student age and classroom grade, to test whether observed trends remain stable.

[10] For the *health* sample, this includes only MdM respondents, information on individual education was not collected for HI respondents.

Table 2. Snapshot of respondent and household profiles

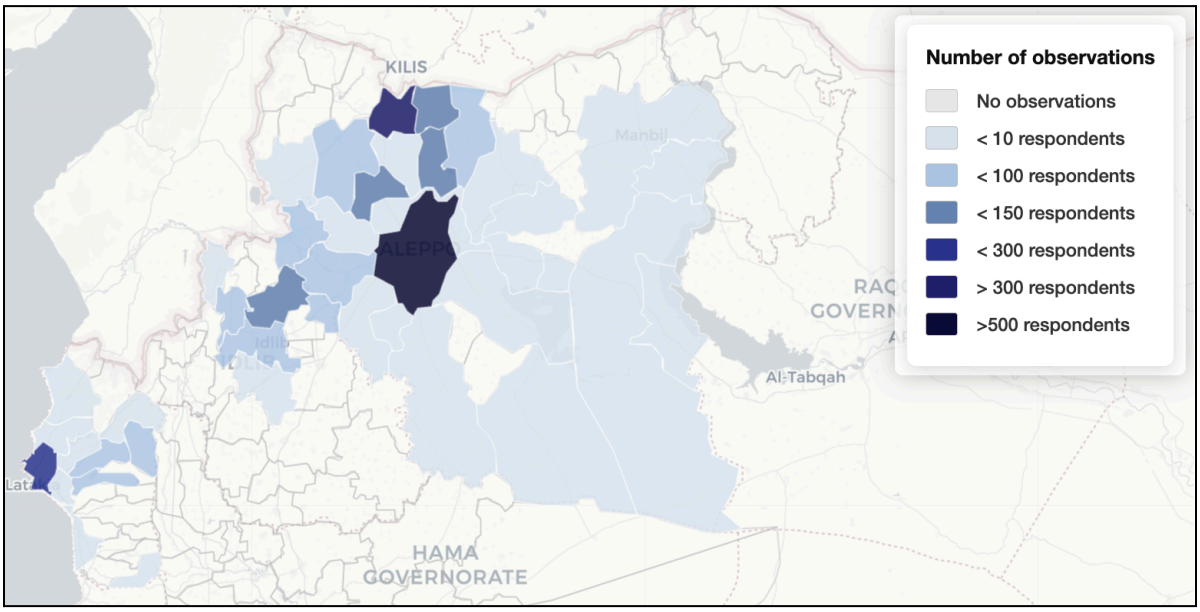
	Overall	*Education*	*Health*	*Livelihood*
n	1963	473	575	915
Respondent profile				
Female (%)	79.1	87.3	60.5	86.4
Age in years	37.6 (12.7)	39.8 (8.2)	41.2 (16.5)	34.1 (10.9)
Education level (%)*				
None or Primary	43.6	0.2	75.7	56.6
Secondary	10.0	2.3	13.4	13.0
Tertiary	46.3	97.5	10.8	30.4
Monthly income (million SYP)	1.0 (1.0)	1.4 (0.4)	0.8 (1.2)	0.9 (1.0)
Married (%)	50.8	75.9	48.5	39.2
Disability (%)	-	-	47.1	-
Household profile				
Female HHH (%)	31.7	24.5	11.7	48.0
Age of HHH	43.5 (13.8)	46.8 (11.1)	45.3 (15.6)	40.6 (13.2)
Educational level of HHH				
None or Primary	53.6	12.4	77.8	63.1
Secondary	12.2	13.9	9.1	12.7
Tertiary	34.2	73.7	13.1	24.2
Monthly income HH	2.3 (1.5)	2.5 (1.3)	2.0 (1.8)	2.3 (1.5)
Number of HH members	5.1 (2.3)	4.4 (2.0)	5.2 (2.8)	5.5 (2.1)
Number of children in HH	2.3 (1.9)	1.9 (1.6)	2.3 (2.1)	2.5 (1.9)
A HH member with disability (%)*	39.1	18.9	64.8	34.1
Governorate				
Aleppo	74.3	43.8	68.9	93.4
Lattakia	10.9	32.6	0.0	6.6
Idleb	14.8	23.7	31.1	0.0
Urban area (%)	60.4	63.0	42.4	70.4
Displacement status (%)				
Resident	72.8	89.6	79.6	59.7
IDP	21.0	6.6	11.1	34.7
Returnee	6.2	3.8	9.2	5.6
Affected by earthquake (%)	77.2	72.1	73.2	82.4

Note: *Means and standard deviations (in parentheses) are reported for continuous variables, and percentages for categorical variables. Missing values are excluded from all calculations.* * *= Variable not collected for HI. A baseline snapshot of household and respondent profiles disaggregated by partner can be found in Appendix A3.*

Nearly a third of all households are headed by a woman, a share that is almost half among livelihood respondents. The average household comprises five members, mostly including two children. The presence of a household member with a disability in 39% of households points to significant care burdens.

Geographically, the overall sample is concentrated in the governorate of Aleppo, while the sector-specific samples show a wider distribution across Aleppo, Idleb, and Lattakia. The *livelihood* respondents are predominantly from Aleppo (94%), while it also accounts for nearly half of the *education* respondents. For the remaining sample, Lattakia plays a prominent role in the *education* sample (32.6%), while Idleb represents the largest share within the *health* sample (31.1%). Figure 2 maps the geographical distribution of respondents at the subdistrict level. While the sample records observations across 46 subdistricts, the geographic focus of the program is highly concentrated, with the top six subdistricts accounting for over 80% of all surveyed households. The largest concentrations of respondents are found in Aleppo city and Azaz, reflecting the predominance of livelihood activities in that area. Around 60% of respondents overall live in urban areas, though the *health* sample is composed of notably more rural respondents (42%), which may have implications for service access and the interpretation of health outcomes (Table 2).

Figure 2. Geographical concentration of respondents



Note: *The map displays the geographical distribution of respondents in the core database at the sub-district level. The darkest areas correspond to sub-districts with the highest respondent concentration. Observations without complete residency data are excluded.*

Displacement and exposure to acute shocks highlight continued structural vulnerabilities in the CREA areas (Table 2). Strikingly, over three-quarters of respondents across all of the samples report having been affected directly by the 2023 earthquakes, a figure broadly consistent across the *education* (72%), *health* (73%), and *livelihood* samples (82%). Nearly a quarter of all respondents are currently internally displaced (over a third among *livelihood* respondents), while returnees account for a smaller yet notable share, particularly in the *health* sample (9%).

3.2 Overview of key outcome indicators

Next, we describe the main outcome indicators focusing on access and quality of education and health services, income generation and sources, mental wellbeing, and social cohesion. Table 3 provides the descriptives for the overall sample for each sector-specific sample.

Access and quality of services

First, regarding access to basic services, 78% of households are directly connected to the national electric grid, yet only 51% of households from the *health* sample have direct access to electricity from the national grid. Water access follows a similar pattern: 65% of households report having running water at home, with this share being higher for teacher households (86%). Among *livelihood* households, 24.5% report access to financial services, of whom only 7.5% actively use them.

Second, regarding access to education, 94% of the children who are enrolled in school attend it on a regular basis. Among those who do not, the main barriers are institutional and economic in nature: the most commonly reported reason is temporary or permanent school closure, followed by the prohibitive costs of schooling, and the need for children to work or support the main household provider. Regarding education quality, respondents rate the classroom environment of their oldest school-child in their household on a scale from 0 to 5, where 0 implies very unsatisfactory and 5 implies very satisfactory quality. On average, respondents rate the classroom environment at 3.37, with slightly lower average scores across school functionality, covering facilities, classrooms, and bathrooms (3.13), and overall satisfaction with education quality (3.23), suggesting moderate but not high perceived school quality. As expected, teachers report somewhat higher scores across all three dimensions, while *livelihood* respondents rate it lowest. Respondents expressed several challenges regarding the educational system. For instance, 75% report a lack of school materials at their children's schools, 50% report a lack of proper hygienic facilities, 48% report Teacher absence, and 47% report very large class sizes (not displayed).

Table 3. Snapshot of key outcome indicators

	Overall	*Education*	*Health*	*Livelihood*
n	1963	473	575	915
Access to basic and financial services				
Access to national electric grid (%)	78.2	88.6	51.3	89.7
Access to running water at home (%)	65.2	85.6	56.5	60.0
Access to financial services (%)	-	-	-	24.5
Use of financial services (%)	-	-	-	7.5
Access to and quality of education services				
Attendance of enrolled children (%)	94.2	97.3	87.1	95.7
Quality: Environment (0-5)	3.4 (1.0)	3.7 (0.9)	3.4 (1.0)	3.2 (1.0)
Quality: Functionality (0-5)	3.1 (1.0)	3.4 (1.0)	2.9 (1.0)	3.1 (0.9)
Quality: Overall satisfaction (0-5)	3.2 (1.1)	3.7 (1.0)	3.2 (1.1)	3.0 (1.0)
Access to and quality of health services				
Seek health services when needed (%)	86.3	81.7	79.9	92.5
Accessibility of health services (1-10)	-	-	4.6 (2.3)	-
Quality: Accessibility (0-5)	3.2 (1.2)	3.4 (1.2)	2.7 (1.3)	3.3 (1.0)
Quality: Affordability (0-5)	2.6 (1.2)	2.7 (1.4)	2.2 (1.2)	2.8 (1.0)
Quality: Functionality (0-5)	3.2 (1.1)	3.2 (1.2)	3.0 (1.2)	3.4 (1.0)
Quality: Time (0-5)	3.4 (1.1)	3.4 (1.2)	3.5 (1.1)	3.3 (1.0)
Income, mental wellbeing and social cohesion				
Monthly income HH (in million SYP)[11]	2.3 (1.5)	2.5 (1.3)	2.0 (1.8)[12]	2.3 (1.5)
Monthly income respondent	1.0 (1.0)	1.4 (0.4)	0.8 (1.2)[13]	0.9 (1.0)
Average # of income sources	1.1 (0.6)	1.3 (0.6)	0.7 (0.5)	1.2 (0.5)
Index for depressive symptoms (0-30)	13.2 (7.6)	9.3 (5.8)	15.1 (6.8)	14.1 (8.1)
Social networks (0-5)	2.7 (1.7)	2.5 (1.7)	1.9 (1.5)	3.3 (1.6)
Trust in education systems (1-4)	2.9 (0.8)	3.1 (0.6)	2.7 (0.8)	2.8 (0.9)
Trust in health systems (1-4)	3.0 (0.8)	2.9 (0.7)	3.0 (0.7)	2.9 (0.9)

Note: *Means and standard deviations (in parentheses) are reported for continuous variables, and percentages for categorical variables. Missing values are excluded from all calculations. A baseline snapshot of outcomes disaggregated by partner can be found in Appendix A3.*

[11] All monetary values are in the old SYP currency prior to the early 2026 redenomination.
[12] Respondent income mostly reflects MdM data, 69% missing in the HI sample.
[13] Household income mostly reflects MdM data, 72% missing in the HI sample.

Third, regarding *access to healthcare*, around 86% of respondents sought medical advice from a doctor or health services the last time they needed it. This share is lower among *health* respondents (around 80%). Among *health* beneficiaries, access to health services is rated 4.62 on a scale from 1 to 10, where 1 means no access at all and 10 means perfect access, underscoring the challenges in accessing health services that the program aims to address.

Economic situation

In terms of economic outcomes, household income is low across the entire sample, at around 2.3 million SYP per month on average, pointing towards financial stress across the sample (Table 3). To contextualize this figure: the World Food Program's Minimum Expenditure Basket stood at approximately 2.2 million SYP per month as of late 2025, with nearly 90% of Syrian households facing difficulties meeting basic needs.[14] The sample average thus sits just barely above this subsistence threshold. Income distributions differ markedly across the respondents from the three CREA sectors. Teachers report the most stable income, where individual incomes average at around 1.4 million SYP per month with only small variance, consistent with their fixed salaries in the public sector. *Livelihood* respondents, on the other hand, show considerably higher variance at the household level. Among the *livelihood* sample, a striking share, approximately one-third, report zero individual income (not displayed). The *health* sample shows the highest household income variance.[15]

On average, most households have only one income source. The households of teachers rely on more diversified income streams (1.34) compared to other respondents, where in many cases, two adults generate income from different sources. In contrast, *health* respondents rely on the fewest income sources (0.67), which implies that some households do not have any source of income, underscoring the precarious economic situation of this group (Table 3).

Figure 3 shows that overall, around 70% of respondents contribute to household income. This share is higher among male respondents (80.6%) than female respondents (68.1%), a gap of around 12 percentage points. Moreover, Figure 4 presents that the average monthly household income is 2.3 million SYP overall. Male-headed households have

[14] See World Bank (2026). *Macro Poverty Outlook, April 2026: Syrian Arab Republic*. Available at https://thedocs.worldbank.org/en/doc/65cf93926fdb3ea23b72f277fc249a72-0500042021/related/mpo-syr.pdf .

[15] Due to the large amount of missing information on income in the health data, the income values in this sector should be interpreted with caution.

higher income on average (2.4 million SYP) compared to female-headed households (2 million SYP), a gap of around 17%.

Figure 3. Contribution of the respondent to the overall household income

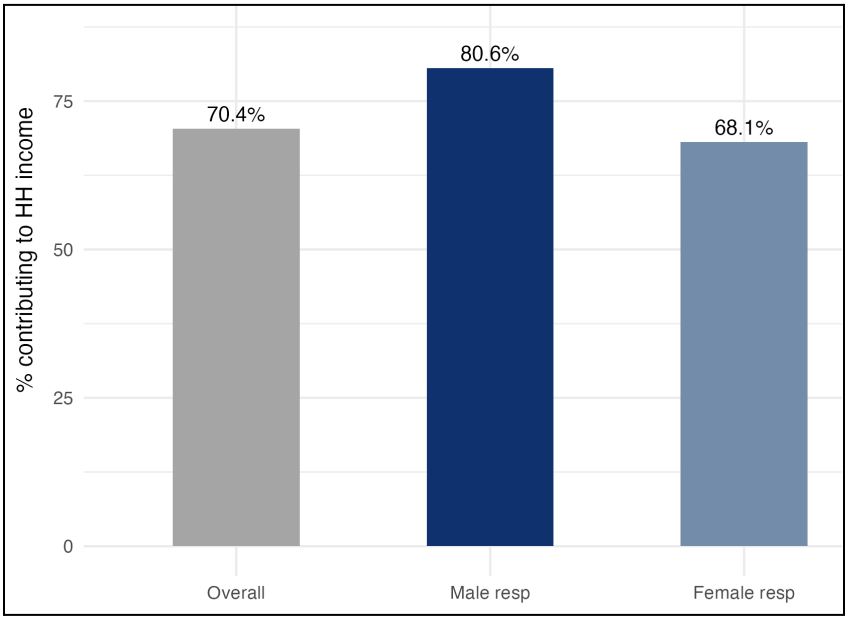
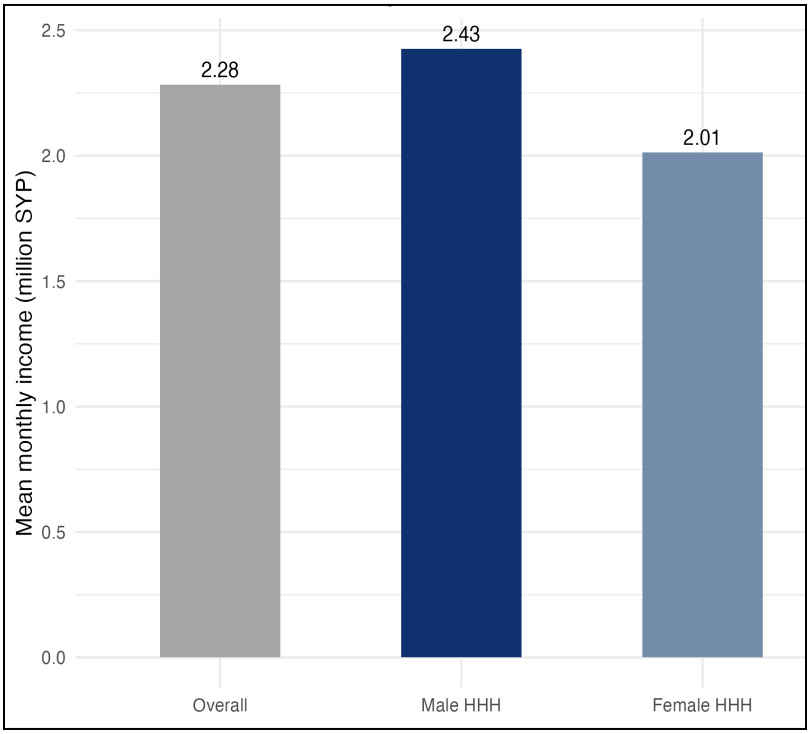
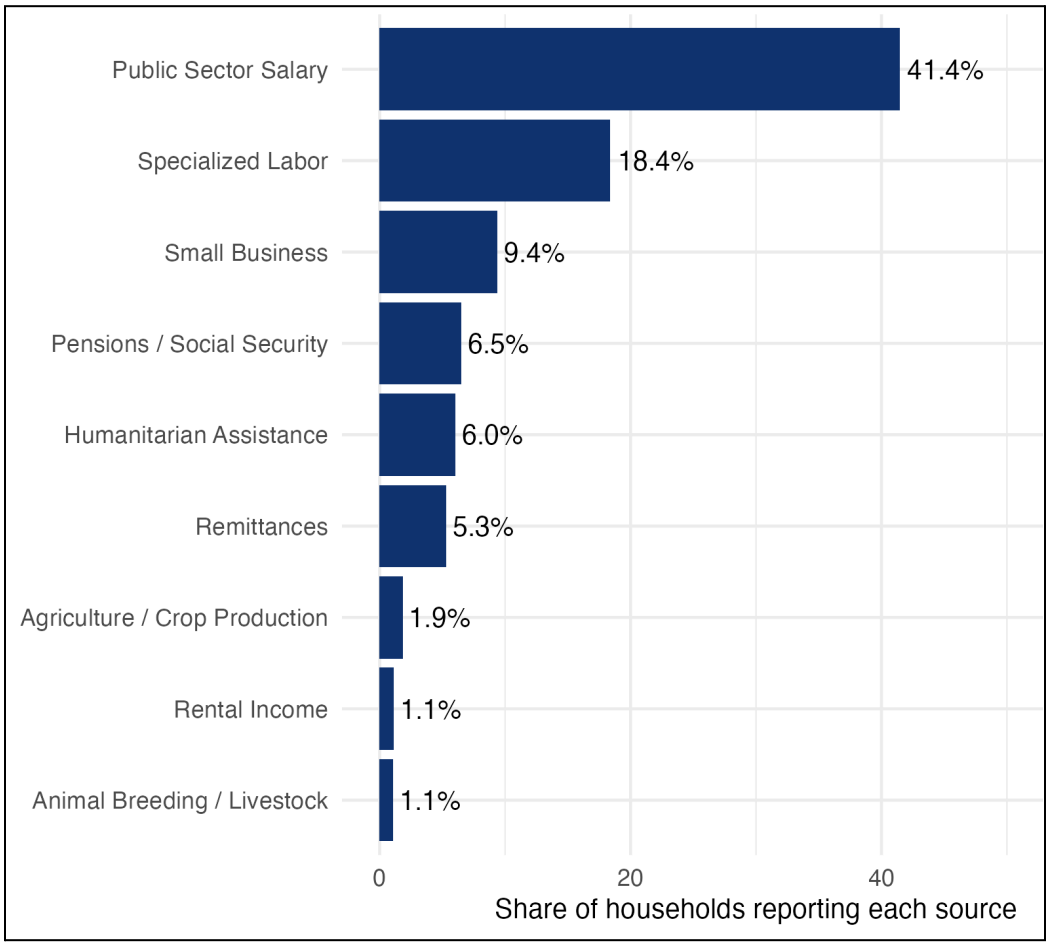


Figure 4. Average household income by household head gender



Additionally, Figure 5 shows the distribution of household income sources across the sample. Public sector salary is by far the most common income source, reported by 41.4% of households, likely reflecting the high share of teachers in the *education* group who receive a government salary. Specialized labor is the second most common source (18.4%), followed by income from operating small businesses (9.4%). The remaining sources, which include pensions and social security, humanitarian assistance, remittances, agriculture, rental income, and animal breeding are each reported by fewer than 7% of households, underscoring the limited income diversification in the sample.

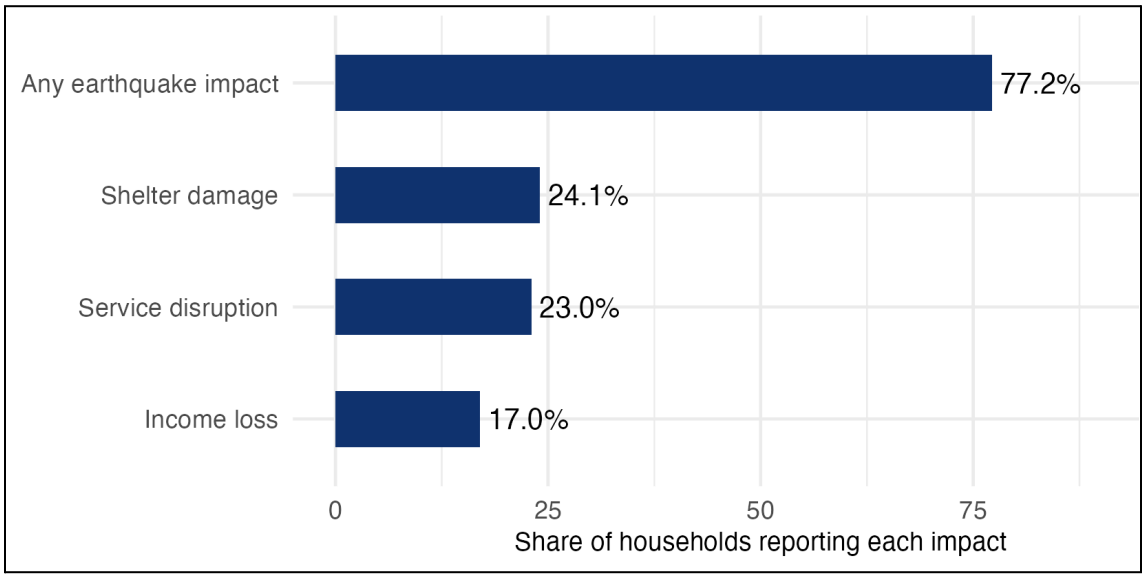
Figure 5. Household income sources



Note: *Income sources are based on the question "From which of these income sources did your household generate income in the past 30 days?" Sources are defined as follows: Public Sector Salary: government employment, including teachers and administration; Specialized Labor: crafts, construction, carpentry, mechanics, tailoring, and similar skilled trades; Small Business: shops, small enterprises, transport, and services; Pensions / Social Security: pension or social security payments; Humanitarian Assistance: cash, vouchers, or in-kind aid; Remittances: money sent from abroad or other areas; Agriculture / Crop Production: income from farming or crop production; Rental Income: income from housing, land, or assets; Animal Breeding / Livestock: income from animal husbandry or livestock.*

Figure 6 shows that the 2023 earthquakes had a widespread impact on the surveyed population, with around 77% of households reporting being affected in some way. Among those affected, the most commonly reported impacts were shelter damage (24.1%) and service disruption (23.0%), while income loss was reported by 17.0% of households.

Figure 6. Households affected by the 2023 earthquake



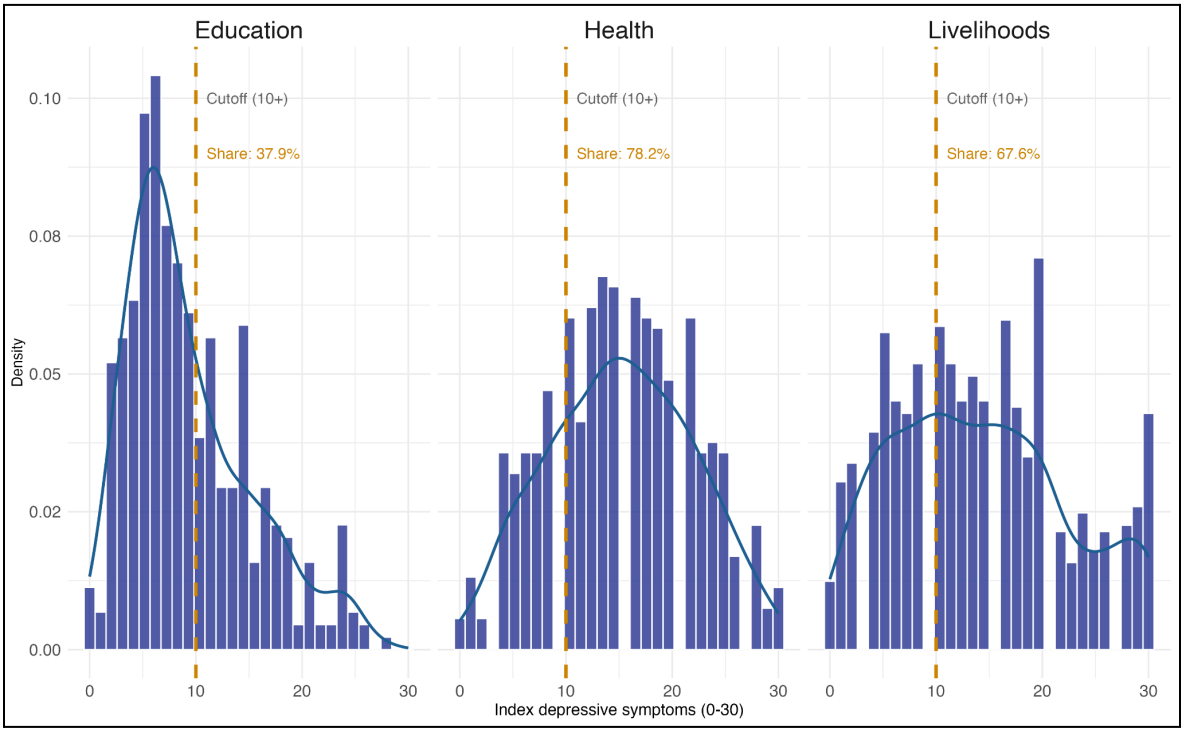
Note: *"Any earthquake impact" is a binary indicator of whether the household reported being affected by the 2023 earthquakes. The remaining bars show the share of households reporting a specific type of impact: shelter damage, service disruption, and income loss.*

Mental well-being

In terms of well-being, respondents report considerable psychological distress at baseline. The average depression index score for the overall sample is 13.2 out of 30. *Health* and *livelihood* respondents reported notably higher average scores (15.1 and 14.1, respectively) compared to teachers (9.3). Accordingly, 64% of the respondents are classified to report depressive symptoms. Figure 7 displays the distribution of the mental health score for each sector-specific sample separately. For teachers, the distribution is left-skewed, which implies that the majority of respondents fall below the cutoff. Around 40% of teachers are classified as having depressive symptoms; however, the largest share of those have scores below 20, as shown in the figure. The *health* and *livelihood* samples display a markedly worrying pattern: both distributions are broadly spread across the full range of the index, with a substantially larger share of respondents falling above the

cutoff, 78.2% of the patients and 67.6% of the *livelihood* respondents, revealing a heightened psychological burden among these two groups.[16]

Figure 7. Prevalence of self-reported depressive symptoms by CREA sector



Note: *Depressive symptoms are measured using the CES-D-10 scale, which aggregates responses to 10 questions about the respondent's feelings over the past week. Individual items are scored on a 4-point scale ranging from "rarely or none of the time" to "most or all of the time." The resulting index ranges from 0 to 30, with scores above 10 used as the clinical cutoff to indicate the prevalence of depressive symptoms. Higher scores reflect greater symptom severity.*

Social cohesion

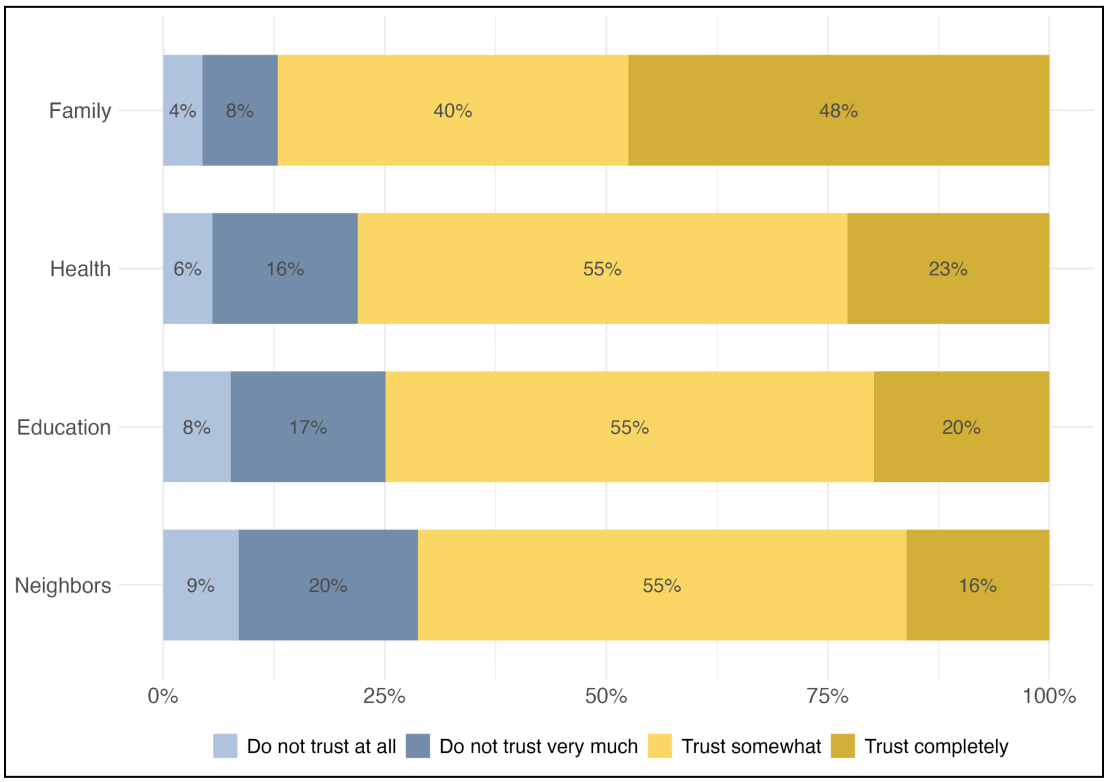
For social networks, we look at an indicator capturing whether respondents know someone who could, for example, lend them a large amount of money or take care of their children. Overall, this averages 2.7 out of 5 across the full sample, indicating a moderate level of social networks where respondents can typically rely on two to three distinct types of support from outside their household (Table 3). *Livelihood* respondents report the

[16] These shares are in line with other prior studies on the prevalence of depressive symptoms among the Syrian population, see e.g. See Aysazci-Cakar, F., Schroder, T., & Hunt, N. (2022). A systematic review of prevalence and correlates of post-traumatic stress disorder, depression and anxiety in the displaced Syrian population. *Journal of Affective Disorders Reports*, 10, 100397; and Mohsen, F., et al. (2021). Psychological health problems among Syrians during war and the COVID-19 pandemic: national survey. *BJPsych International*, 18(3), E8.

highest average score (3.3), suggesting relatively stronger social networks, while *health* respondents score markedly lower (1.9), which reveals that health participants may lean towards being more socially isolated. Teachers fall close to the overall mean (2.5).

Trust in education and health systems is measured on a scale from 1 (do not trust at all) to 4 (trust completely), where higher scores indicate higher trust. Across the full sample, respondents report moderate levels of trust in the education and health systems, averaging 2.87 and 2.95, respectively (Table 3). As expected, teachers report the highest trust in education systems (3.09), while patients have the lowest (2.70). Trust in health systems is comparatively more uniform across all samples, ranging from 2.92 among *livelihood* respondents to 3.01 among *health* respondents.

Figure 8. Trust levels in family, neighbors, health, and education systems



Note: *Trust levels are measured separately for four groups: family members, neighbors, doctors and healthcare providers, and educators and educational institutions. Responses are recorded on a 4-point scale: 1 = Do not trust at all, 2 = Do not trust very much, 3 = Trust somewhat, 4 = Trust completely. Bars show the percentage of respondents selecting each response category.*

Notably, trust in institutional actors in the education and health system is higher than trust in neighbors and the broader community (but not higher than trust in family), as shown in Figure 8. This pattern is particularly pronounced among *health* respondents (not displayed), indicating that institutional trust remains comparatively resilient in this context, even when informal bonds of neighborhood trust are weak.

3.3 Student profile and outcomes

In addition to the *core database*, and as part of the *education* IE, we collected data from 1,138 female students. As shown in Table 4, 512 are enrolled in Grade 9 and 626 in Grade 10. The mean age of students in the sample is 15 years. The majority of students are located in Aleppo (54.2%), followed by Idleb (31.8%) and Lattakia (14.0%).

Table 4. Snapshot of student sample

	Overall	*9th grade*	*10th grade*
n	1,138	512	626
Age in years	15.2 (1.0)	14.9 (1.1)	15.4 (0.8)
Governorate			
Aleppo	54.2	65.2	45.5
Idleb	31.8	20.6	40.6
Lattakia	14.0	14.2	13.9
Belief-in-self (0-27)	17.5 (4.6)	18.5 (4.6)	16.7 (4.5)
Emotional competence (0-27)	18.9 (4.3)	19.2 (4.1)	18.7 (4.5)
Symptoms of depression (0-12)	5.2 (2.3)	5.2 (2.3)	5.1 (2.3)
Symptoms of anxiety (0-18)	8.5 (3.6)	8.42 (3.7)	8.6 (3.5)

Note: *Means and standard deviations (in parentheses) are reported for continuous variables, and percentages for categorical variables. Missing values are excluded from all calculations. A baseline snapshot of outcomes disaggregated by partner can be found in Appendix A3.*

Socio-emotional outcomes are captured through two indices. The belief-in-self index averages 17.5 overall, with Grade 9 students scoring notably higher (18.5) than Grade 10 students (16.7). Emotional competence averages 18.9, with scores broadly similar across grades. On average, students' depressive symptoms score 5.2 overall (on a scale from 0 to

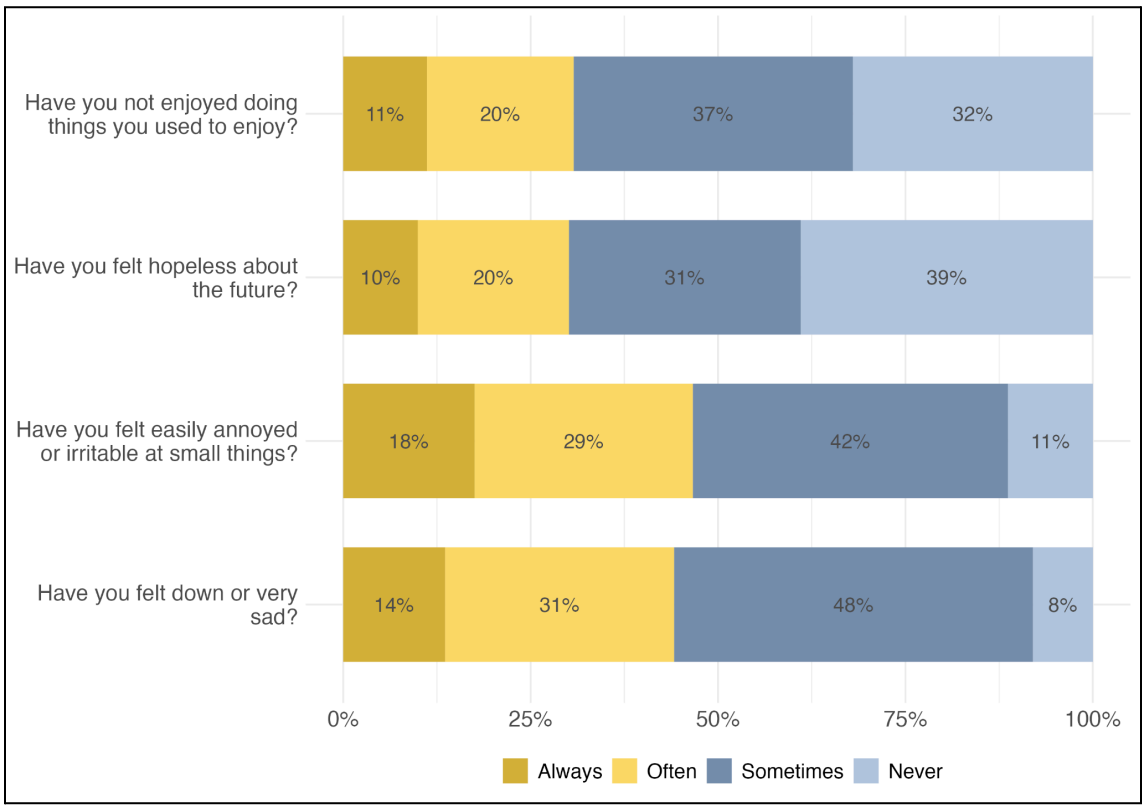
12)[17], with virtually no difference between Grade 9 (5.2) and Grade 10 (5.1) students, which represents a moderate-to-low symptom burden on average. Anxiety symptoms, average at 8.5, again with minimal variation across grades.[18]

Figure 9a displays the individual symptoms of depression. Irritability and sadness are the most common: 47% of students report feeling easily annoyed or irritable at small things always or often, and 45% report feeling down or very sad with the same frequency. Not enjoying the things one used to enjoy and hopelessness are somewhat less prevalent, with 31% reporting they always or often no longer enjoy things they used to, and 30% reporting feeling hopeless about the future always or often. Notably, however, the '*never*' response is rare across all items. Notably, only 11% of the students report having never felt irritable, and only 8% of students report having never felt down or very sad in the past two weeks, suggesting that while severe and persistent symptoms are less prevalent, very few students are entirely unaffected.

[17] Depressive symptoms among students were measured using a distinct tool tailored to adolescents, and therefore are not comparable to the adult score for depressive symptoms measured using the CESD-10.

[18] Symptoms of depression and anxiety are assessed using the Measuring Mental Health among Adolescents and Young People (MMAP) tool. Symptoms of depression are captured across four items (feeling down or sad, irritability, loss of enjoyment in previously liked activities, and hopelessness about the future), yielding a total score of 0 to 12. Symptoms of anxiety are captured across six items (feeling worried or nervous, doubting one's abilities, worrying about others' perceptions, fearing bad events, excessive worrying, and inability to control worries), yielding a total score of 0 to 18. Both indices are scored from 0 (never) to 3 (always) per item. As no clinical cut-offs have been established for the Syrian population, scores should be interpreted as indicators of self-reported emotional distress rather than clinical diagnoses.
Belief-in-self and emotional competence are measured following the Socio-emotional Health Survey - Secondary, each captured through three sub-indices of three items scored from 0 (never) to 3 (always), yielding a total score of 0 to 27. Belief-in-self covers self-efficacy, self-awareness and persistence; emotional competence covers emotional regulation, empathy and self-control. Emotional competence is captured through emotional regulation, empathy and self control, each consisting of three survey items.

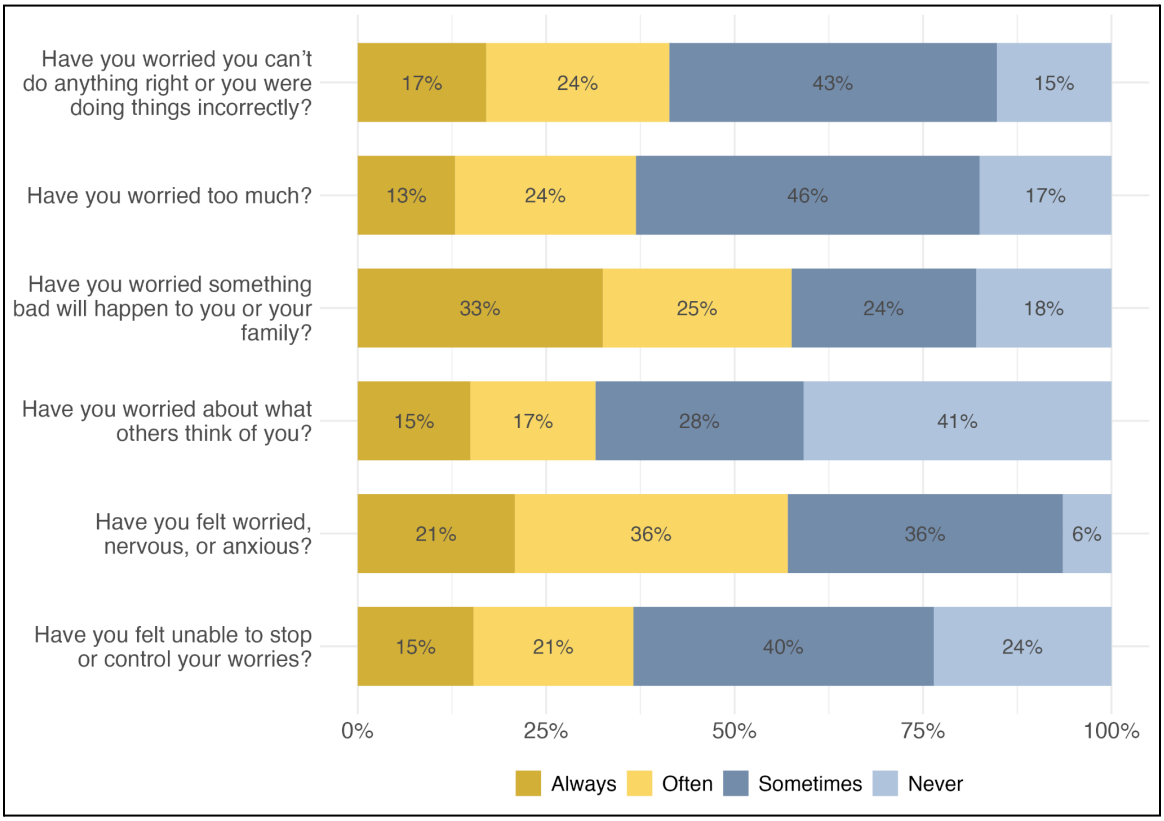
Figure 9a. Prevalence of symptoms of depression among female adolescent students



***Note**: Symptoms of depression are measured using the Measuring Mental Health among Adolescents and Young People (MMAPP) tool. Students were asked to report these symptoms for a recall period of the past 2 weeks. Bars show the percentage of respondents selecting each response category.*

Figure 9b describes the anxiety symptoms, which are more pronounced and more uniformly elevated than depressive symptoms. 58% of the students always or often worry that something bad will happen to them or their family, reflecting the tangible insecurity of the conflict and post-earthquake context. General anxiety is also widespread among female adolescents, with 57% always or often feeling worried, nervous, or anxious.

Figure 9b. Prevalence of symptoms of anxiety among female adolescent students



***Note**: Symptoms of anxiety are measured using the Measuring Mental Health among Adolescents and Young People (MMAPP) tool. Students were asked to report these symptoms for a recall period of the past 2 weeks. Bars show the percentage of respondents selecting each response category.*

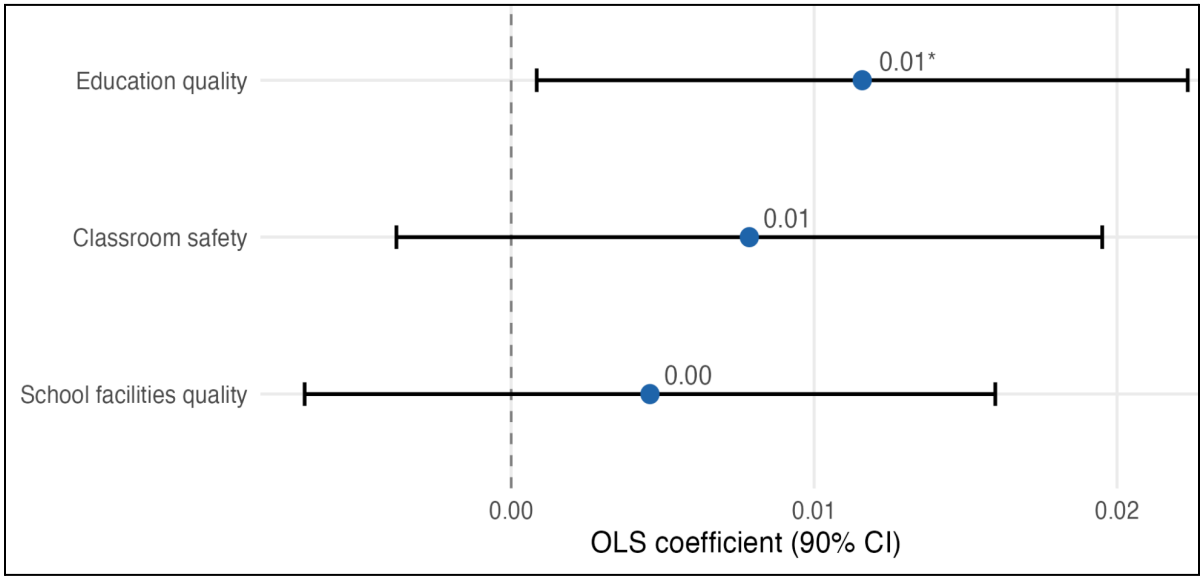
4 Baseline analytical findings

4.1 Access and quality of services

To gain insights into the benefits of accessibility and quality of *education services*, Figure 10 studies how these are associated with children's school attendance. Of the three dimensions examined, the household's satisfaction with overall education quality is associated with higher regular school attendance. This effect is small but notably robust; it remains stable in magnitude and significance across other model specifications.

Moreover, several household characteristics emerge as consistent predictors of regular school attendance (reported in Annex 2). Households where the head has secondary or tertiary education are more likely to have children attending school regularly. Children of older household heads are less likely to attend school regularly, while children in households with higher incomes are more likely to attend on a regular basis. The remaining dimensions, such as the quality of school facilities and classroom safety, are not statistically associated with regular school attendance.

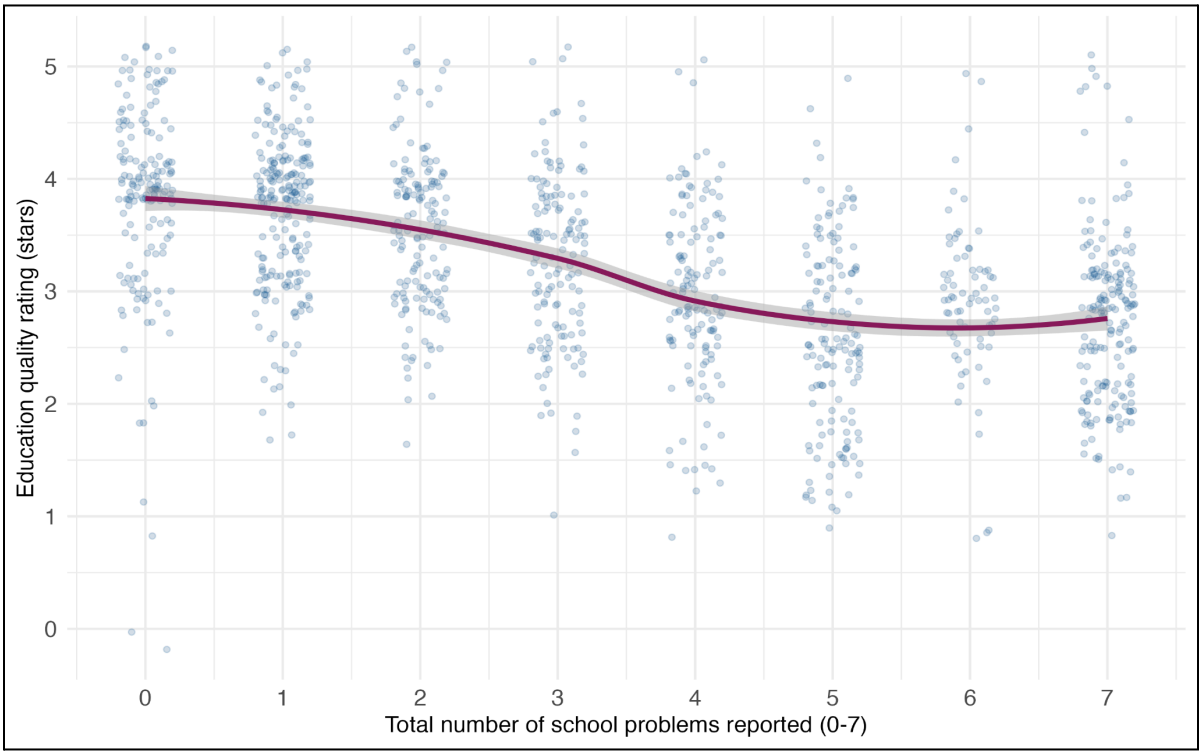
Figure 10. Association between satisfaction with school quality and regular attendance



Note: *The outcome variable, school attendance, is measured as: "Do all the enrolled children in your household attend school on a regular basis?" Predictors are rated on a 0–5 Likert scale: Satisfaction with education quality: "Overall, how satisfied are you with the quality of education at the child's school?"; School facilities quality: "Overall, how do you rate the functionality of the child's school, i.e. the facilities, classrooms, bathrooms?"; Classroom safety: "Overall, how would you rate the classroom environment at the child's school in terms of safety?" * = p < 0.1, ** = p < .05, *** = p < .01.*

Figure 11 illustrates how a household's overall education quality rating (average of all three quality ratings reported by respondents) is linked with the number of challenges experienced by their child at school, such as teacher absences, the lack of school material. The analysis reveals that as the number of reported problems increases from 0 to 7, average education quality ratings decline steadily from around 4 to approximately 2.5. The decline is steepest between 0 and 3 problems, after which the curve flattens somewhat, suggesting diminishing marginal effects at higher problem counts. Notably, even households reporting no problems show considerable variation in quality ratings, indicating that other factors beyond the presence of specific problems also shape satisfaction with education quality.

Figure 11. Association between satisfaction with school quality and the number of school problems reported

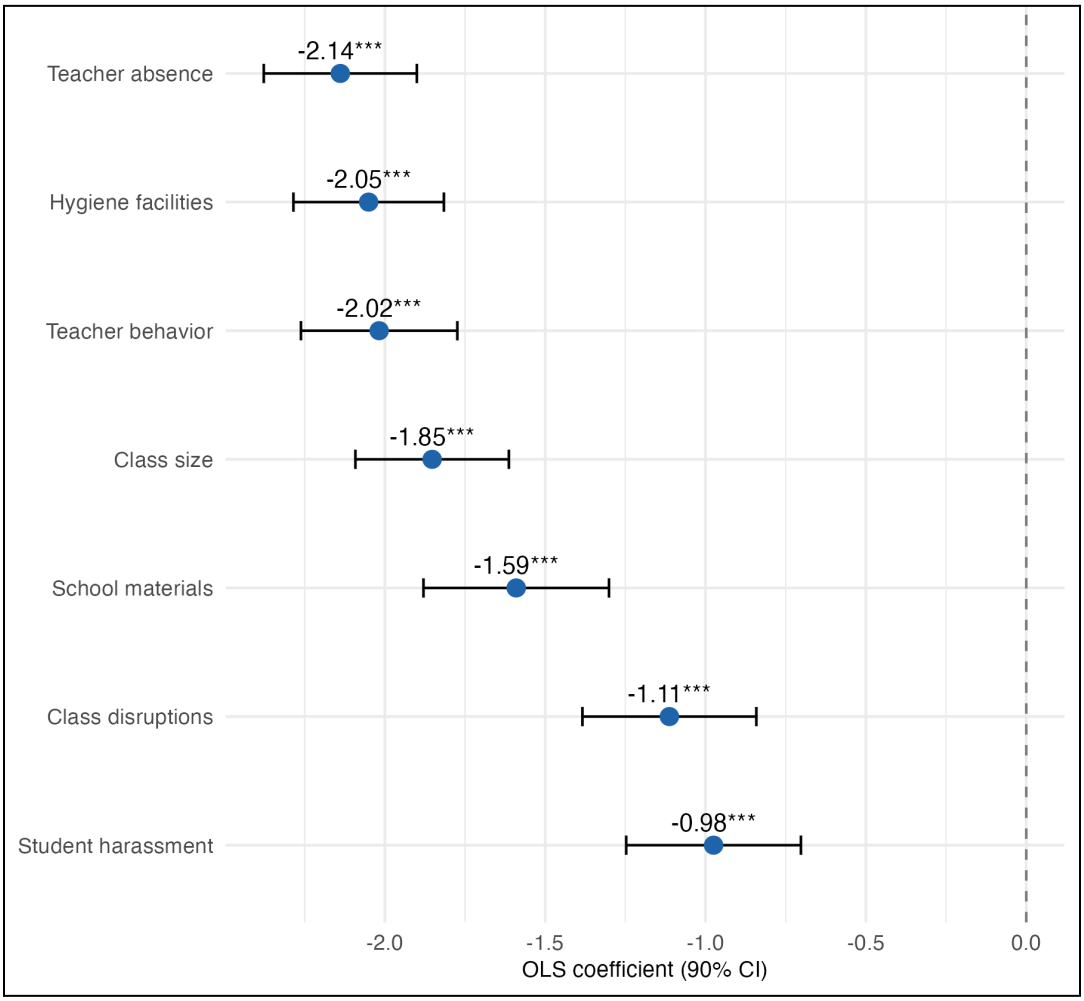


Note: *Problems include teacher absence, problems with teachers, problems with students, class disruptions, class size, lack of school material, and lack of proper hygienic facilities. Education quality rating here averages all three distinct quality ratings regarding the environment, functionality and overall satisfaction with education services. The line represents the LOESS fit.*

Disaggregating by problem type, Figure 12 presents the drivers of perceived education

quality. All seven school problems are associated with lower satisfaction with education quality, indicating that each problem perceived by households can contribute to less satisfaction with education services. The associations are strongest for teacher absence (associated with a -2.14-point decrease), hygiene facilities (-2.05), and teacher behavior (-2.02), suggesting that staffing reliability and basic school conditions are key for satisfaction in education quality. Class size (-1.85) and lack of school materials (-1.59) also show large and significant negative associations, followed by class disruptions (-1.11) and student harassment (-0.98).

Figure 12. Association between satisfaction with school quality and each school problem

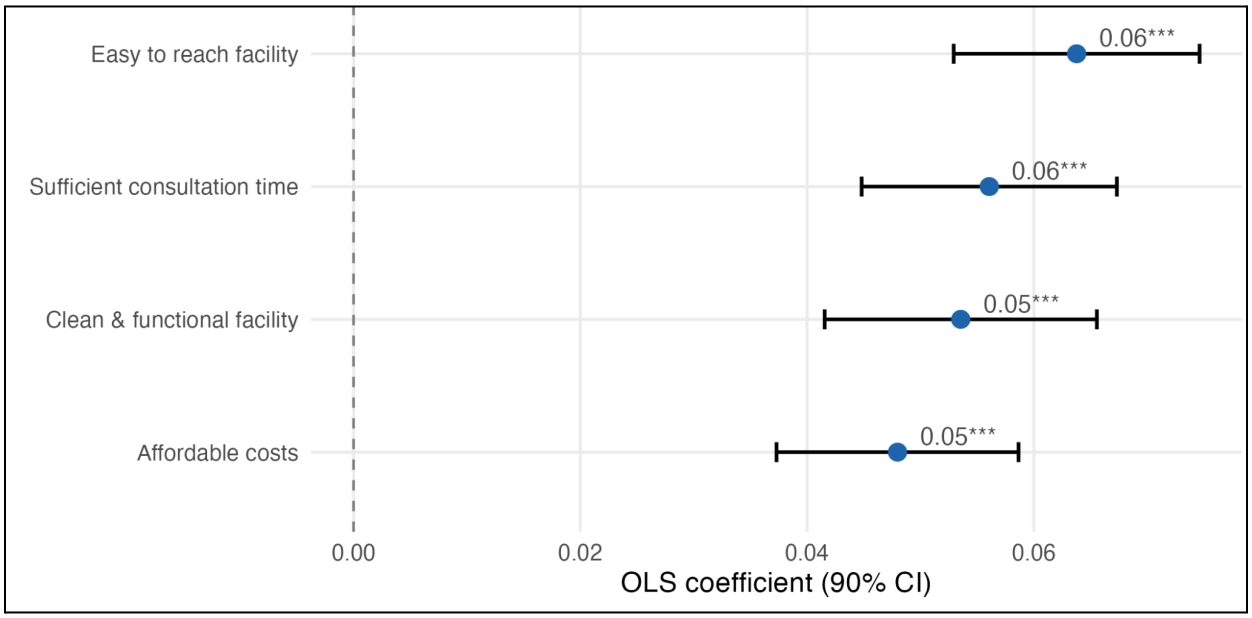


Note: *The outcome variable is an education quality score computed as the sum of three rated dimensions (functionality, environment, and satisfaction), yielding a composite score ranging from 0 to 15. Predictors are binary indicators of whether each problem was reported as occurring: Teacher absence, lack of hygienic facilities, problems with the teacher, problems with class size, lack of school materials, class disruptions, and student harassment. * = p < 0.1, ** = p < .05, *** = p < .01.*

Overall, the strong association of perceptions of school problems and perceptions of education quality has a clear programmatic implication: addressing supply-side deficiencies related to school problems is a promising and effective way of improving households' satisfaction with the education system overall, which may in turn support longer-term engagement and retention.

To understand the role of healthcare accessibility and quality in shaping healthcare utilization, Figure 13 examines how respondents' health quality ratings are related to whether households visited a doctor or sought medical advice the last time a household member fell sick or was injured. Each of the four measures of health service quality is associated with households utilizing healthcare more. Households are 5-6 percentage points more likely to seek medical help when they have a health problem for each of the following: the presence of a facility that is easy to reach, having sufficient consultation time, a clean and functional facility, and affordable costs

Figure 13. Association between satisfaction with healthcare quality and healthcare utilization



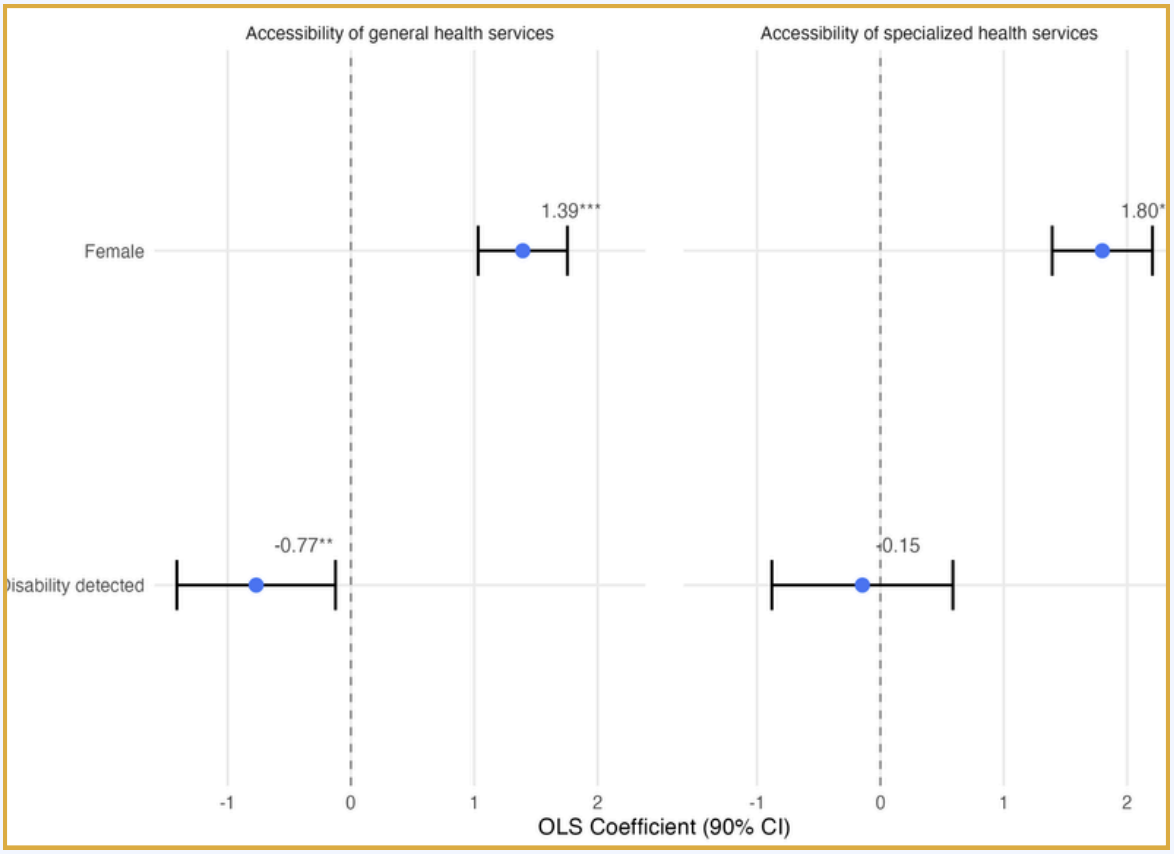
Note: *The outcome variable health-seeking behaviour is measured as: "The last time you (or a member of your household) was sick or injured, did you/they visit a doctor or seek medical help?". Predictors are rated on a 0–5 Likert scale: Sufficient consultation time: "The doctor/nurse spent enough time during the consultation"; Affordable costs: "The costs for healthcare/treatment services were affordable"; Clean & functional facility: "The healthcare facilities were clean, functional and in good condition"; Easy to reach facility: "It was easy to get to the place where I (or a member of my household) received medical treatment".* * = p < 0.1, ** = p < .05, *** = p < .01.*

Spotlight Health: Disability and gender shape the accessibility of health services

Moving from what shapes the utilization of healthcare services when needed, we now turn to the factors associated with healthcare accessibility itself. To identify structural barriers, we assess the accessibility of general and specialized health services, focusing on the ratings by CREA health sector patients in Figure 14.

Female respondents in the health sample report significantly higher accessibility for both general and specialized health services. Respondents with a disability report a significant accessibility deficit for general health services, pointing towards barriers people with disabilities face in accessing health services.

Figure 14. Differences in health service accessibility by gender and disability status of the respondent

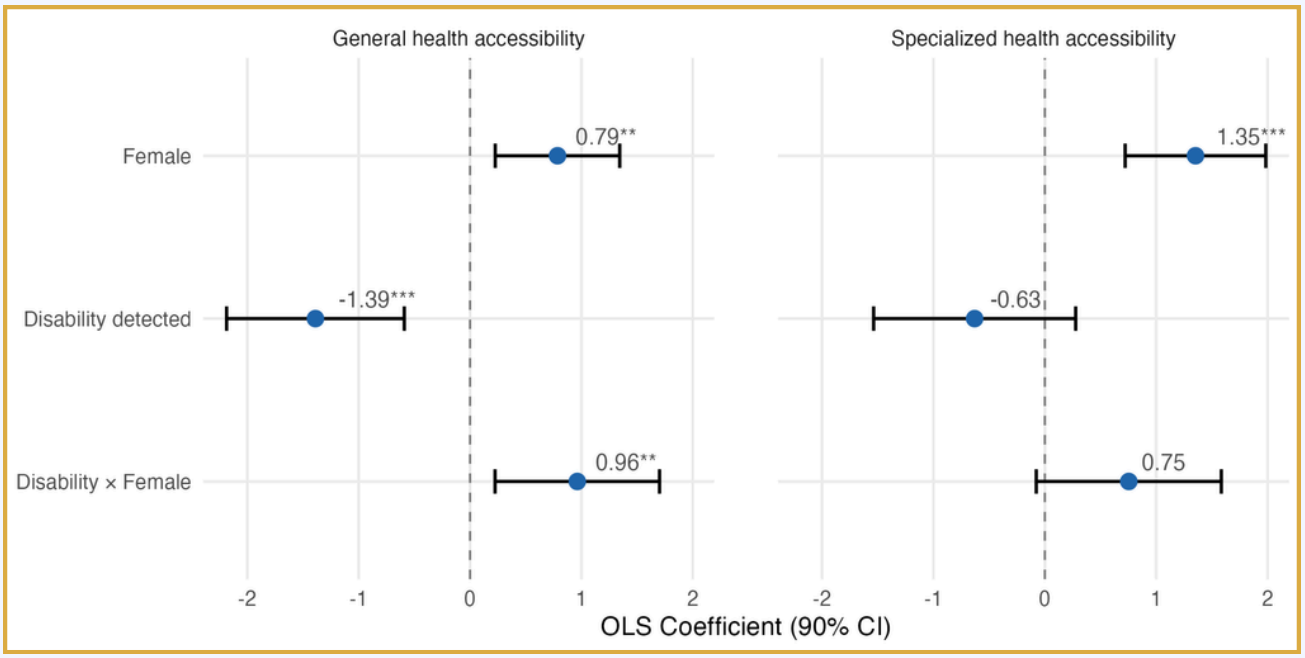


Note: *Accessibility of general health services is measured as: "On a scale from 1 to 10, how accessible were health services to you in the past six months? (1 = not accessible at all, 10 = very easily accessible)". Accessibility of specialized health services is measured as: "On a scale from 1 to 10, how accessible were specialized health services to you in the past six months? (1 = not accessible at all, 10 = very easily accessible). * = p < 0.1, ** = p < .05, *** = p < .01.*

To examine whether these two dimensions compound one another, we introduce an interaction between disability status and gender. The results reveal an important heterogeneity: the accessibility challenges associated with a disability are concentrated among male respondents, while the interaction term (Disability × Female) indicates that female respondents with disabilities report fewer access barriers than male respondents with disabilities (Figure 15).

This does not imply that women with disabilities face no barriers, but rather that acute accessibility issues in the sample are disproportionately reported by men with disabilities. For specialized health services, the gender gap remains pronounced (1.35, $p<0.01$), but the disability interaction is not statistically significant, suggesting that barriers to specialized care operate through different channels.

Figure 15. The role of gender and disability status in health service accessibility

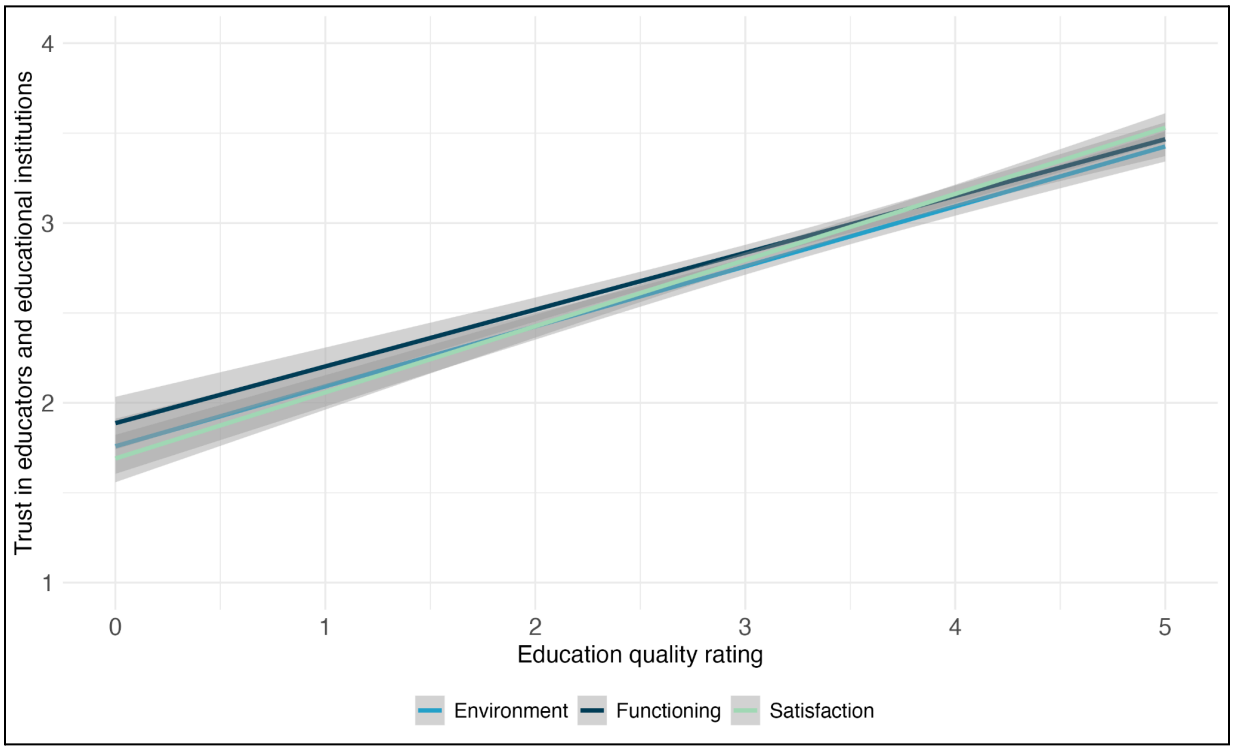


Note: *The coefficients are estimated within the same regression model and include the main effects of respondent gender and disability as well as their interaction term. Accessibility of health services is measured as: "On a scale from 1 to 10, how accessible were health services to you in the past six months? (1 = not accessible at all, 10 = very easily accessible)". Accessibility of specialized health services is measured as: "On a scale from 1 to 10, how accessible were specialized health services to you in the past six months? (1 = not accessible at all, 10 = very easily accessible). * = p < 0.1, ** = p < .05, *** = p < .01.*

Quality of education services and trust in the education system

To examine how improvements in school quality influence trust in the education system, Figure 16 models the relationship between trust and quality satisfaction in the education system. The association appears linear across the range of observed quality ratings, suggesting predictable returns: improvements in perceived school quality are associated with higher trust in the education system, and vice versa. As illustrated in the figure, even when respondents rate the quality of education services at the absolute lowest (0), their average trust level does not drop to *'Do not trust at all' (1).*

Figure 16. Association between trust in educators/educational institutions and caregivers' rating of educational quality



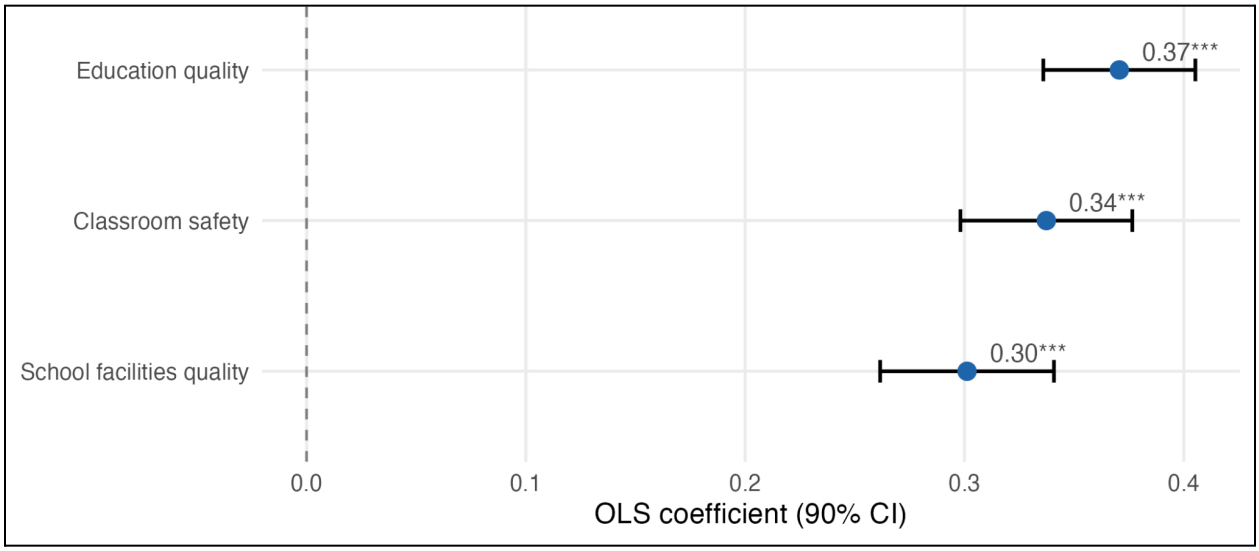
Note: *Each line shows the association between trust in educators and educational institutions and education quality ratings. Trust is measured on an ascending 4-point scale where higher numeric values indicate greater levels of trust (1 = Do not trust at all, 2 = Do not trust very much, 3 = Trust somewhat, 4 = Trust completely).*

Figure 17 presents the association between perceived education quality and trust in educators and educational institutions. In contrast to the attendance findings, all three quality dimensions show strong, positive, and highly significant associations with trust: classroom environment (0.34, $p<0.01$), the functionality of school facilities (0.30, $p<0.01$), as well as overall satisfaction with the education quality (0.37, $p<0.01$). These coefficients

are stable across all model specifications, suggesting that the relationship between quality perceptions and institutional trust is robust and not driven by differences across households. The magnitude is also large, on a 4-point trust scale, ranging from (1) *Do not trust at all* to (4) *Trust completely*; a one-unit improvement in any quality dimension is associated with roughly 0.30-0.37 points higher trust level. This means that moving a school's quality rating up by just one point closes nearly a third of the difference to the higher trust rating.

Among the control variables, two findings stand out consistently across the models. First, married respondents report significantly lower trust in the education system. Second, households that have members with disabilities report lower trust, suggesting that families with additional vulnerabilities may have less positive experiences with educational institutions. Larger households also tend to report slightly lower trust, while older household heads are associated with marginally higher trust.

Figure 17. Predictors of trust in educators and educational institutions



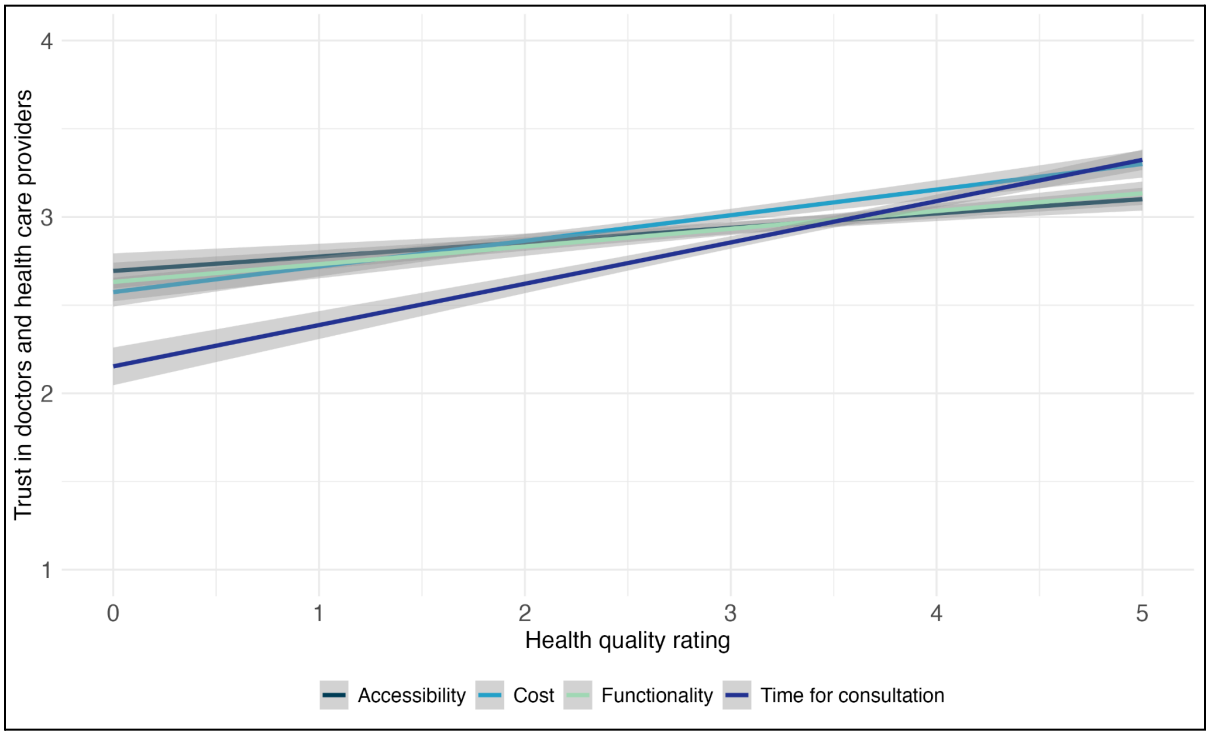
Note: *The outcome variable, trust in educators and educational institutions, is measured on a 1 to 4 scale ranging from (1) Do not trust at all to (4) Trust completely: "How much do you currently trust the following people and organizations?— Educators and educational institutions in your region." Predictors are rated on a 0–5 Likert scale: Satisfaction with education quality: "Overall, how satisfied are you with the quality of education at the child's school?"; Classroom safety: "Overall, how would you rate the classroom environment at the child's school in terms of safety?"; School facilities quality: "Overall, how do you rate the functionality of the child's school, i.e. the facilities, classrooms, bathrooms?". * = p < 0.1, ** = p < .05, *** = p < .01.*

Quality of health services and trust in the health system

To examine whether improvements in the healthcare system mirror the trends observed for the education system, Figure 18 models the relationship between health quality

ratings and trust in doctors and healthcare providers. The data reveals a similar pattern of resilient trust under strained conditions. As illustrated by the model's y-intercepts, when respondents rate core features like accessibility, cost, and the facility's functionality at the absolute lowest (0), trust again does not drop to *'Do not trust at all'* (1); instead, it rests much higher, between the *'Do not trust very much'* (2) and *'Trust somewhat'* (3) thresholds. Although less steep, the association appears approximately linear across the range of observed quality ratings: improvements in perceived health service quality are associated with higher trust in the healthcare system, and vice versa. Notably, the slope for *'Time for consultation'* is steeper than the rest, which indicates that direct contact with medical personnel more strongly drives trust levels.

Figure 18. Association between trust in doctors/health care providers and respondents' rating of health services quality

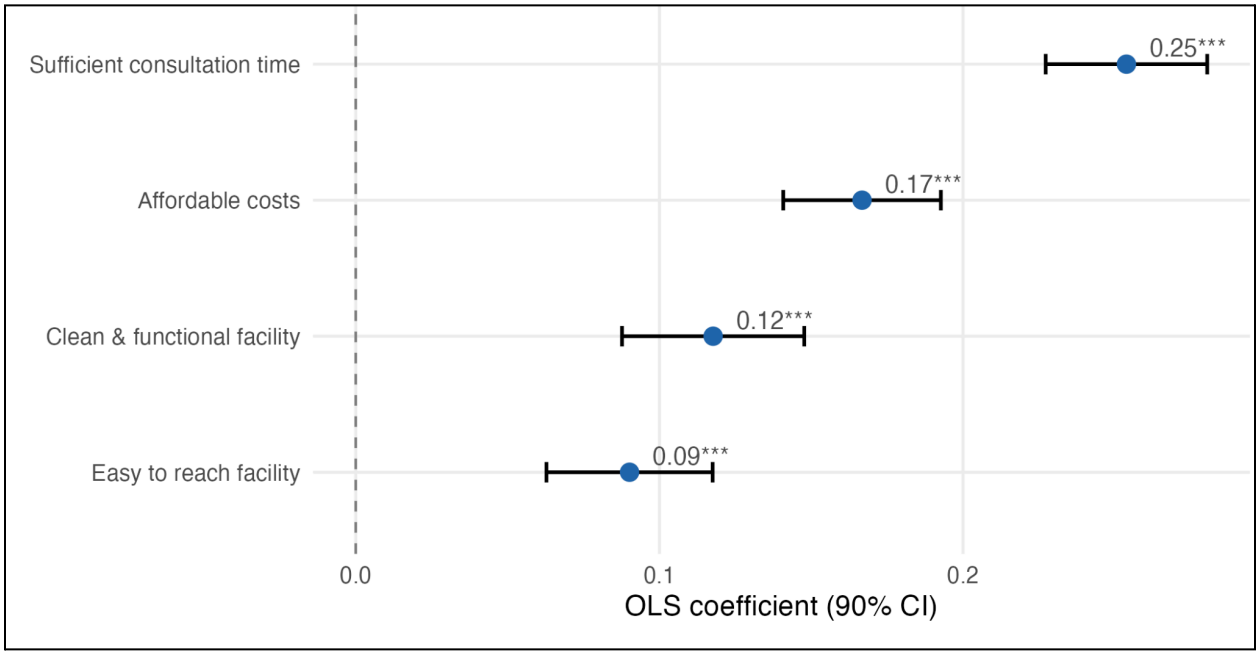


Note: *Each line shows the association between trust in health providers and health institutions and health quality ratings. Trust is measured on an ascending 4-point scale where higher numeric values indicate greater levels of trust (1 = Do not trust at all, 2 = Do not trust very much, 3 = Trust somewhat, 4 = Trust completely).*

Figure 19 presents the association between perceived health service quality and trust in doctors and healthcare providers. Mirroring the findings for the education system, all four health quality dimensions show positive and highly significant associations with trust ($p<0.01$), reinforcing the pattern that quality perceptions are a strong and consistent driver of institutional trust across the sample. The largest effect is found for sufficient

consultation time (0.25), suggesting that feeling heard and adequately attended to during medical consultations is the most important quality dimension for building trust in healthcare providers. Affordable costs (0.17) and clean and functional facilities (0.12) also show meaningful positive associations, while easy access to the facility shows the smallest but still significant effect (0.09).

Figure 19. Health service factors associated with trust in doctors and healthcare providers



Note: *The outcome variable trust in doctors and healthcare providers is measured on a 1 to 4 scale ranging from (1) Do not trust at all to (4) Trust completely: "How much do you currently trust the following people and organizations? — Doctors and health care providers." Predictors are rated on a 0–5 Likert scale: Sufficient consultation time: "The doctor/nurse spent enough time during the consultation"; Affordable costs: "The costs for healthcare/treatment services were affordable"; Clean & functional facility: "The healthcare facilities were clean, functional and in good condition"; Easy to reach facility: "It was easy to get to the place where I (or a member of my household) received medical treatment". * = p < 0.1, ** = p < .05, *** = p < .01.*

Moreover, the full regression tables (reported in Annex 2) reveal several patterns among other variables. Returnee households consistently report significantly lower trust in healthcare providers across all four quality dimensions, even after controlling for quality perceptions and household characteristics. Households that have members with disabilities also report consistently lower trust, a pattern that also appeared in the education trust models, suggesting households with members with disabilities are more likely to have worse experiences with public services more broadly.

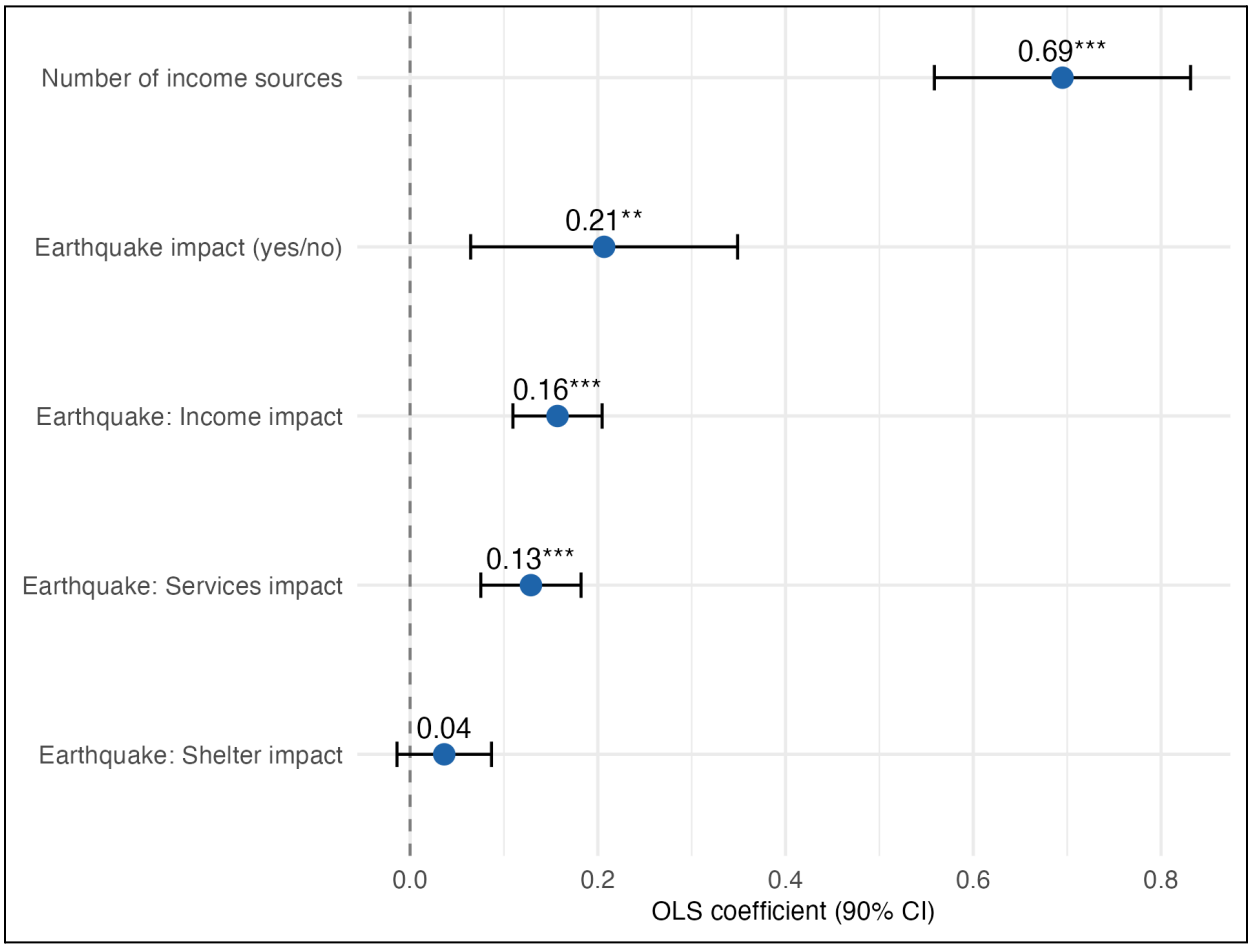
4.2 Economic situation

To better understand differences in household economic well-being, Figure 20 examines how household income is associated with livelihood diversification and earthquake-related impacts. In particular, we assess whether households with more income sources report higher incomes and whether earthquake-related disruptions are associated with differences in monthly household income (Figure 20). The number of income sources is by far the strongest predictor: each additional income source is associated with 0.69 million SYP higher monthly income, although with a wide confidence interval reflecting substantial variation across households. Regarding earthquake impacts, households reporting a general earthquake impact also tend to report *higher* incomes: on average, those reporting earthquake impacts report 0.21 million SYP more per month. We see a similar pattern for specific income or services impacts of the earthquake: households reporting these report higher incomes, on average, than those not reporting impacts (0.16 and 0.13 million SYP, respectively). Earthquake shelter impact shows no significant association with income (0.04, $p>0.1$), suggesting that housing damage alone does not predict income levels once other household characteristics are accounted for.

Higher average income among those reporting earthquake impacts may be counterintuitive. One possible explanation may be that households with higher incomes own more assets, operate businesses, or rely on livelihoods that are more exposed to earthquake-related disruptions, making them more likely to report impacts. Alternatively, prior aid and recovery support targeted at affected households may contribute to this pattern. We would like to emphasize that this pattern warrants further investigation in collaboration with GIZ and local partners to better understand the mechanisms underlying the observed patterns.

The analysis also reveals that households that have members with disabilities earn significantly less across all models (-0.30 to -0.34 million SYP, $p<0.01$), making it the most robust household-level predictor of lower income. Displacement also emerges as an important factor as IDP households earn around 0.18 million SYP less per month in the income sources model, while returnee households show even less income, ranging from -0.19 to -0.31 million SYP across the earthquake models. Married respondents consistently earn more (+0.28–0.37 million SYP, $p<0.01$), and larger households also have more income on average (+0.04–0.05 million SYP per additional member, $p<0.01$).

Figure 20. Earthquake experience, income sources, and their association with household income



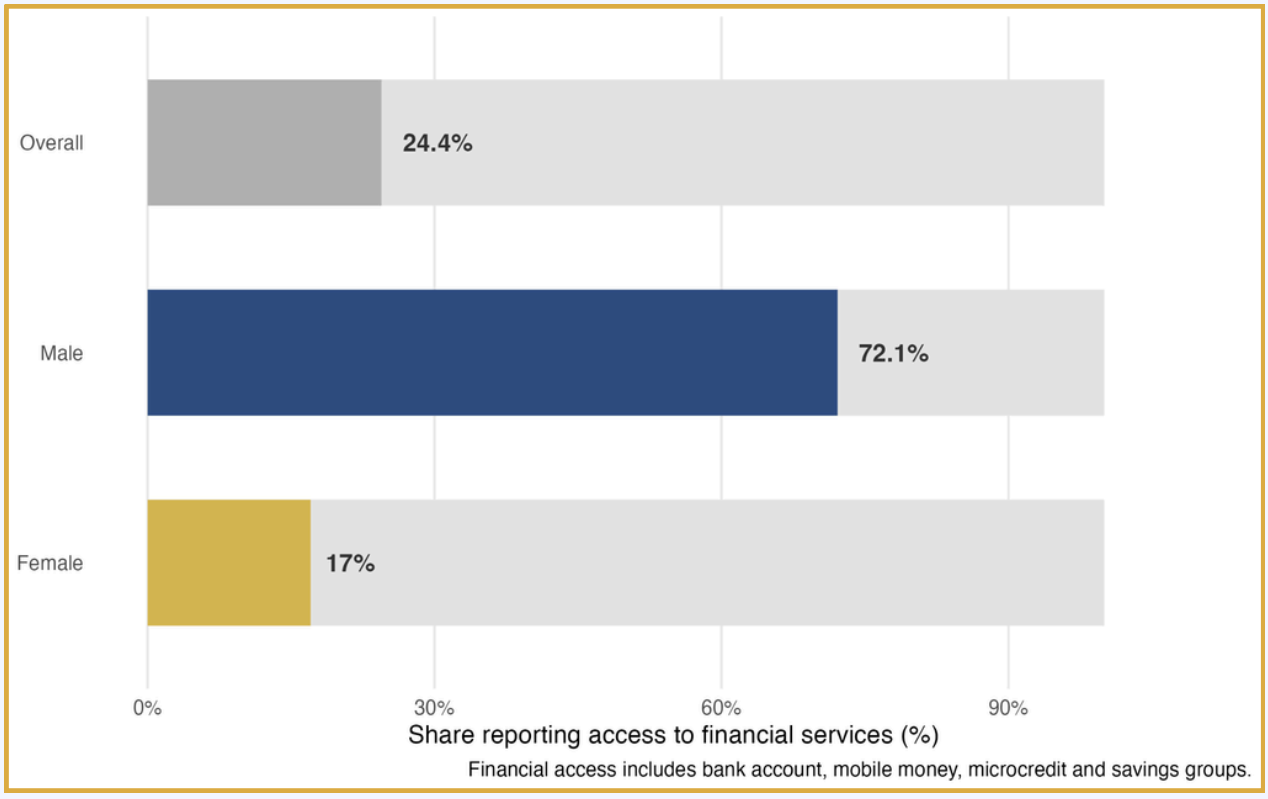
Note: *The outcome variable is total household income in the past 30 days (millions of SYP). The number of income sources counts how many of the following the household reported using: specialized labor, small business, public sector salary, pensions, agriculture, livestock, remittances, rental income, and humanitarian assistance. Earthquake impact variables are binary indicators of whether the household reported that the earthquake affected each domain. * = p < 0.1, ** = p < .05, *** = p < .01.*

Spotlight Livelihoods: Gendered disparities in access to financial services and economic returns

Nearly a quarter (24.4%) of livelihood participants report that their household has access to formal or informal financial services, though active utilization is lower, with only 12% having used a loan, credit, or other financial service within the past six months (Table 3).

This access remains heavily gendered. As illustrated in Figure 21, male respondents report significantly higher rates of both overall access (72.1%) and active usage (19.7%) compared to female respondents, who experience severely constrained rates of access (17.0%) and usage (5.6%).

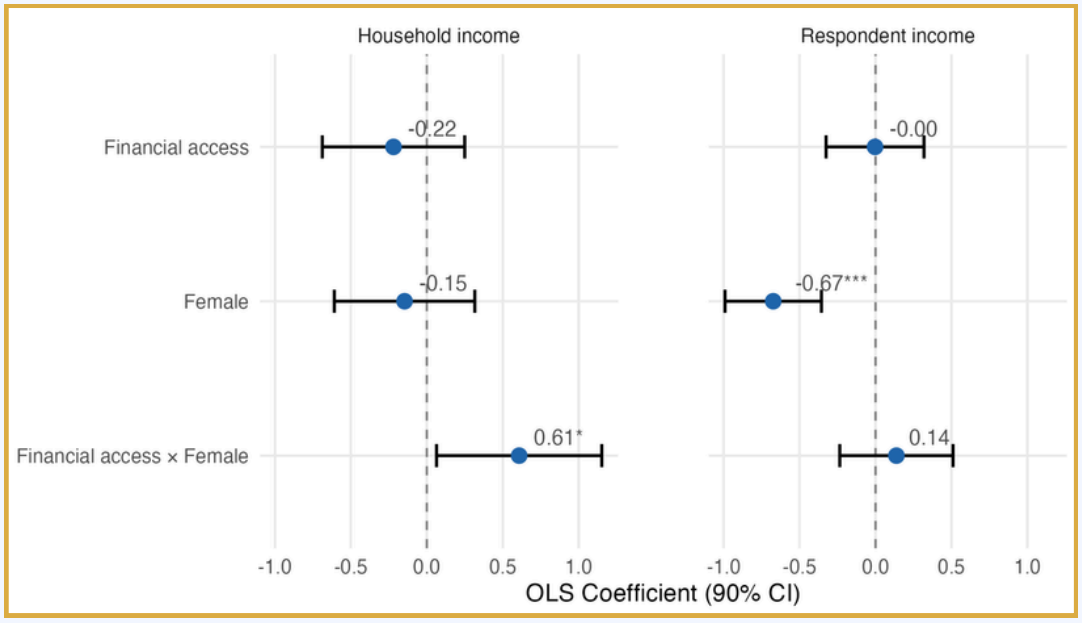
Figure 21. Access to financial services by the gender of the respondent



Note: *Access to financial services is a binary indicator measured as "Does your household have access to financial services (bank account, mobile money, microcredit, savings groups)?"*

To evaluate how financial inclusion influences economic outcomes, we examine the relationship between financial access and income, focusing on potential variations by gender (Figure 22). The results reveal important heterogeneity. Looking first at the drivers of income (reported in Annex 2), a stark gender difference is evident. While being a female respondent has no statistically significant effect on overall household income, it is associated with lower individual earnings, with women earning substantially less than their male counterparts across all model variations. This structural gender gap remains clearly visible when analyzing the interaction, testing whether financial access yields a stronger income effect for women. The interaction term (Financial access × Female, 0.61, p<0.1) indicates that female respondents with access to financial services report higher household income. At the individual level, the gender gap in respondent income is large and robust (-0.67, p<0.01), and financial access does not significantly close it (0.14, p>0.1). Taken together, this suggests that access to financial services holds particular promise for improving household-level economic outcomes, but that structural barriers to women's individual incomes persist beyond what financial access alone can address.

Figure 22. The role of access to financial services and the gender of the respondent for income outcomes

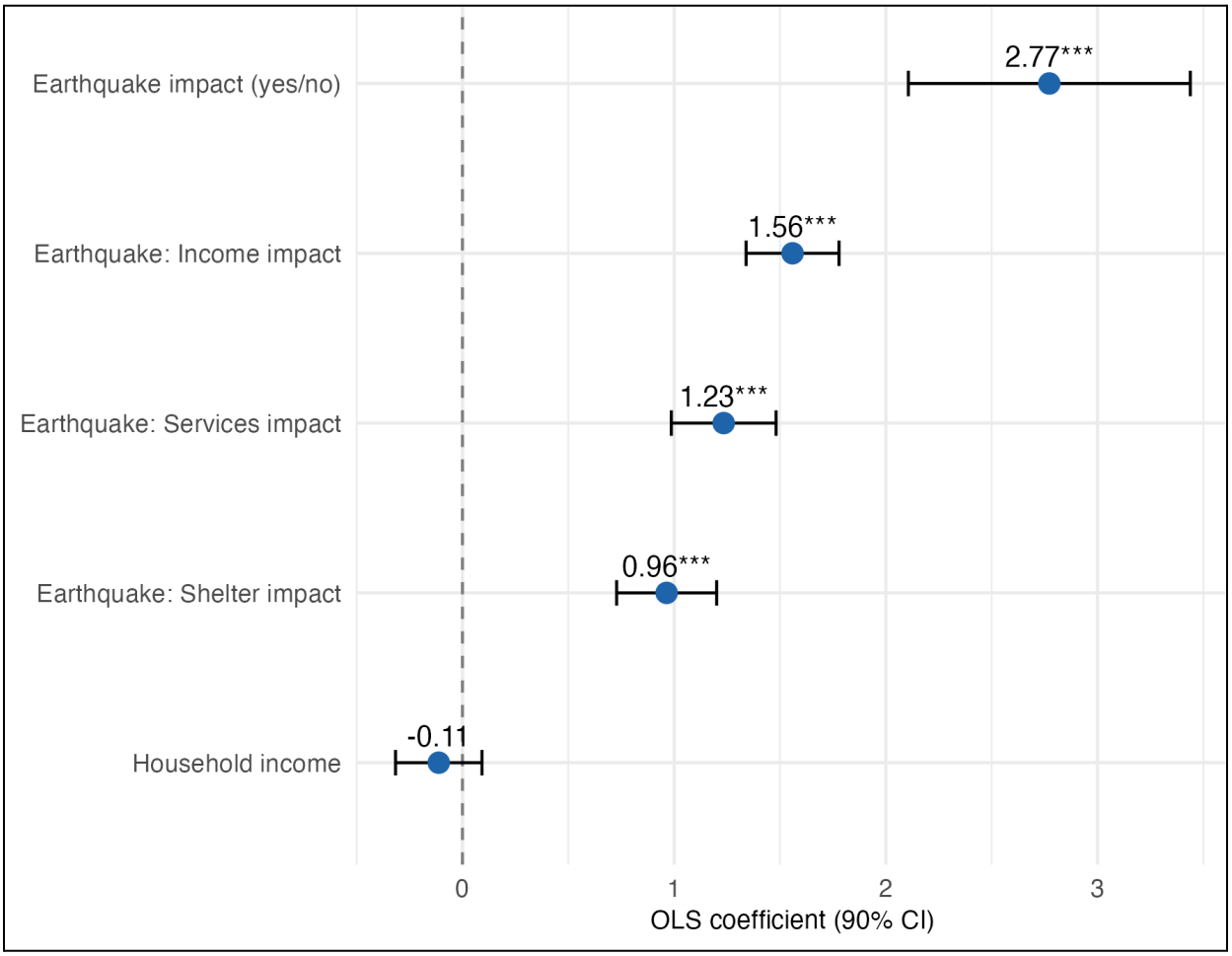


Note: *The coefficients are estimated within the same regression model and include the main effects of respondent gender and disability as well as their interaction term. The outcome variables are total household income (left) and total respondent income (right) in the past 30 days (millions of SYP). Predictors are financial access, a binary indicator measured as "Does your household have access to financial services (bank account, mobile money, microcredit, savings groups)?" and respondent gender. * = p < 0.1, ** = p < .05, *** = p < .01.*

4.3 Mental well-being

To better understand the factors associated with mental well-being, we examine how depressive symptoms vary with household economic circumstances and earthquake-related impacts. Figure 23 presents factors associated with depressive symptoms, measured using the CES-D-10 scale.

Figure 23. Earthquake experience as predictors of depressive symptoms



Note: *The outcome variable is depressive symptoms measured using the CES-D-10 scale (range 0–30; scores above 10 indicate clinically relevant depressive symptoms; higher scores reflect greater severity). "Household income" is the total income in the past 30 days across all sources (millions of SYP). "Earthquake impact (yes/no)" is a binary indicator of whether the household was affected by the 2023 earthquakes. "Earthquake: Income impact", "Earthquake: Services impact", and "Earthquake: Shelter impact" are binary indicators of whether the earthquake affected each specific domain. * = p < 0.1, ** = p < .05, *** = p < .01.*

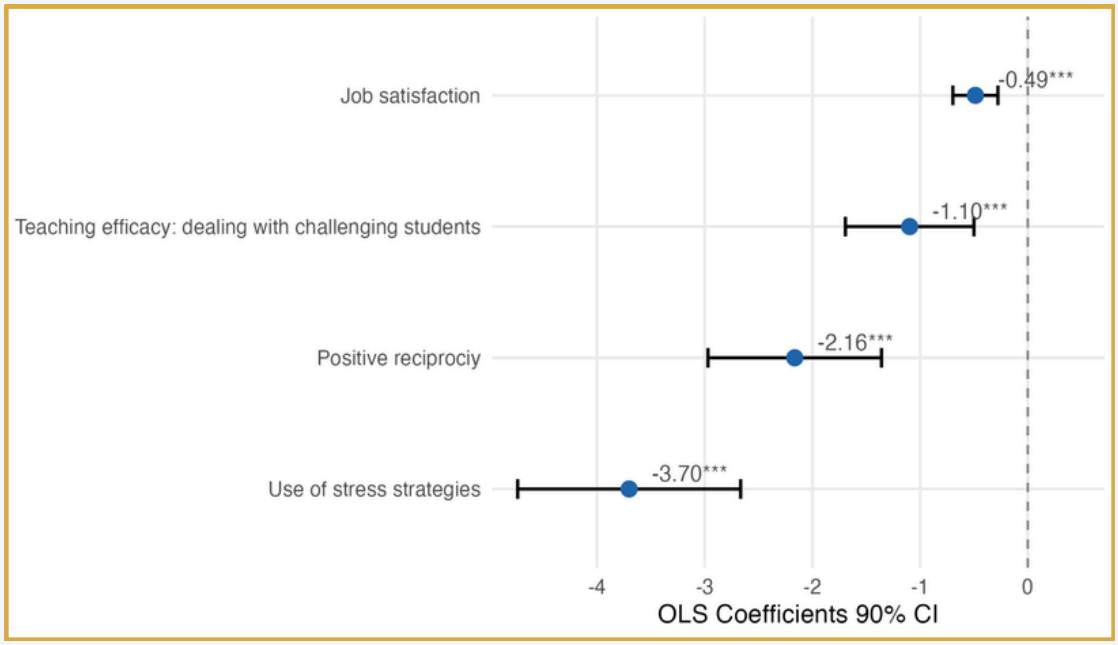
The associations are clear: earthquake exposure is the strongest predictor of depressive symptoms in the sample. Households reporting a general earthquake impact score 2.77 points higher on the scale for depressive symptoms ($p<0.01$), a substantively large coefficient given the scale ranges from 0 to 30. Among the specific impact dimensions, income loss shows the strongest association (1.56, $p<0.01$), followed by disruption to services (1.23, $p<0.01$) and shelter damage (0.96, $p<0.01$), suggesting that the economic and material consequences of the earthquake are strongly correlated with worse mental well-being. By contrast, depression symptom levels do not vary with current income levels.

Spotlight Education: Teacher well-being spills over into the classroom

To better understand the factors associated with teachers' mental well-being outcomes, we analyze the relationship between professional and psychosocial drivers and self-reported depressive symptoms.

The results, visualized in Figure 24, highlight that four factors are significantly associated with a reduction in depressive symptoms.

Figure 24. Professional characteristics associated with depressive symptoms for teachers



Note: *Each estimate is derived from a separate ordinary least squares (OLS) regression model. Coefficients can be interpreted as the average change in the outcome associated with a one-unit change in the explanatory variable in each row. The outcome, teacher depressive symptoms, is measured using the CES-D-10 scale, ranging from 0 to 30, with higher scores reflecting greater symptom severity. The predictors are described as: Job satisfaction ranging from 0 to 10; Efficacy measures agreement to the statement "If I try really hard, I can get through to even the students with the most challenging behavior"; Positive reciprocity captures agreement to the statement "When someone does me a favor, I am willing to return it". Both Efficacy and Reciprocity items range on an agreement scale from 1 to 5, with higher values indicating higher agreement. Use of stress strategies is measured as a binary indicator on "Do you currently have any personal strategies to take care of your own well-being, for example through activities, habits, or support systems you use to mitigate stress?" * = p < 0.1, ** = p < .05, *** = p < .01.*

Notably, teachers who report using stress management strategies score on average 3.70 points lower on the depressive symptom scale (which ranges from 0-30), the strongest association observed across all factors examined. This is followed by positive reciprocity (-2.16, p<0.01) and teaching efficacy, specifically in dealing with challenging students (-1.10, p<0.01): teachers who report stronger agreement with positive reciprocal behavior and greater confidence in managing challenging students report lower depressive symptom scores. Higher job satisfaction also provides a statistically significant, though smaller effect (-0.49, p<0.01).

Given that these, particularly integrating ways to deal with stress as routines, are components of the MHPSS-centered teacher training package, these findings are in line with the program logic: equipping teachers with psychosocial strategies holds potential to improve their mental well-being. Table 5 presents the average depressive symptom scores for teachers and students by governorate.

Teacher mental well-being varies considerably across regions, with Aleppo recording the highest average depressive symptom score (10.96 out of 30), notably above the clinical threshold, followed by Lattakia (9.42) and Idleb (6.46). Student depressive symptoms, measured on a separate 0–12 scale, show less geographic variation, with scores broadly similar in Aleppo and Idleb, and slightly fewer symptoms in Lattakia.

Table 5. Average depressive symptoms by school governorate

	Teachers		Students	
Governorate	Num. Obs.	Average Depressive symptoms	Num. Obs.	Average Depressive symptoms
Aleppo	207	10.96	604	5.32
Idleb	112	6.46	354	5.32
Lattakia	154	9.42	180	4.25

To assess whether teacher mental well-being extends into the classroom, affecting student well-being, we analyze school-level averages of both teacher depressive symptoms and positive reciprocity and how these correlate with student depressive symptoms (Figure 25).[19] A one-unit increase in average teacher depressive symptoms is associated with a 0.06-point increase in the student depression index, while schools with higher average teacher positive reciprocity report significantly lower student symptom scores (-0.72). Although the effect size of teacher depression is modest at the individual level, it operates at the school level, meaning this reflects the cumulative psychological climate of the teaching staff rather than any single teacher's state.[20]

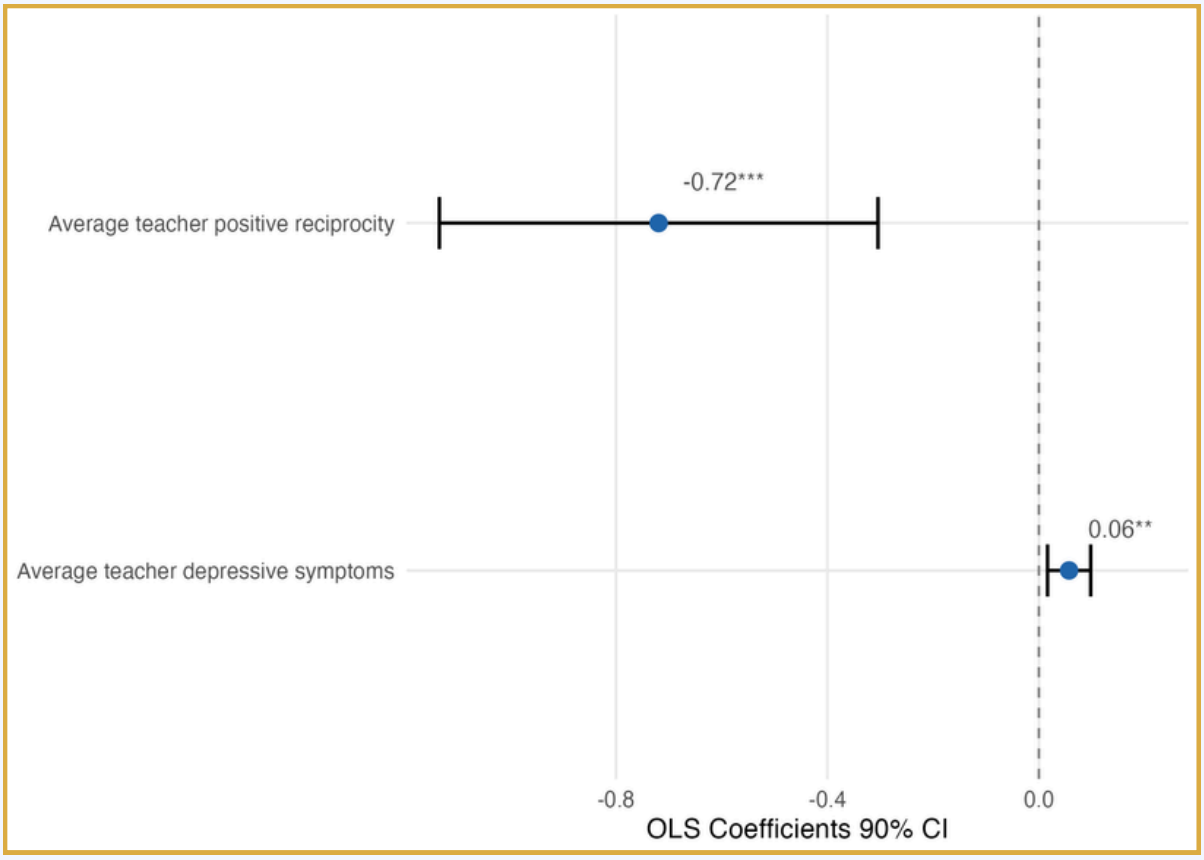
[19] The student-level analyses follow an adjusted approach, given the limited data collected for students. These models control for partner-specific differences, student age and classroom only.

[20] The school-level aggregation used here reflects the constraints of the baseline data structure, in which teachers and students cannot yet be matched at the classroom level. For the impact analyses, direct teacher-to-classroom linkages will be established, which will allow for individual-level estimation of teacher effects on student outcomes.

Taken together, these findings suggest a transmission pathway from teacher to student wellbeing: schools where teachers experience higher psychological distress and lower prosocial orientation are also schools where students report slightly more depressive symptoms.

This reinforces the program logic from a student welfare perspective: investments in teacher mental health and psychosocial skills may not only benefit teachers themselves but may also generate downstream positive effects for students.

Figure 25. Association between teacher characteristics and student depressive symptoms

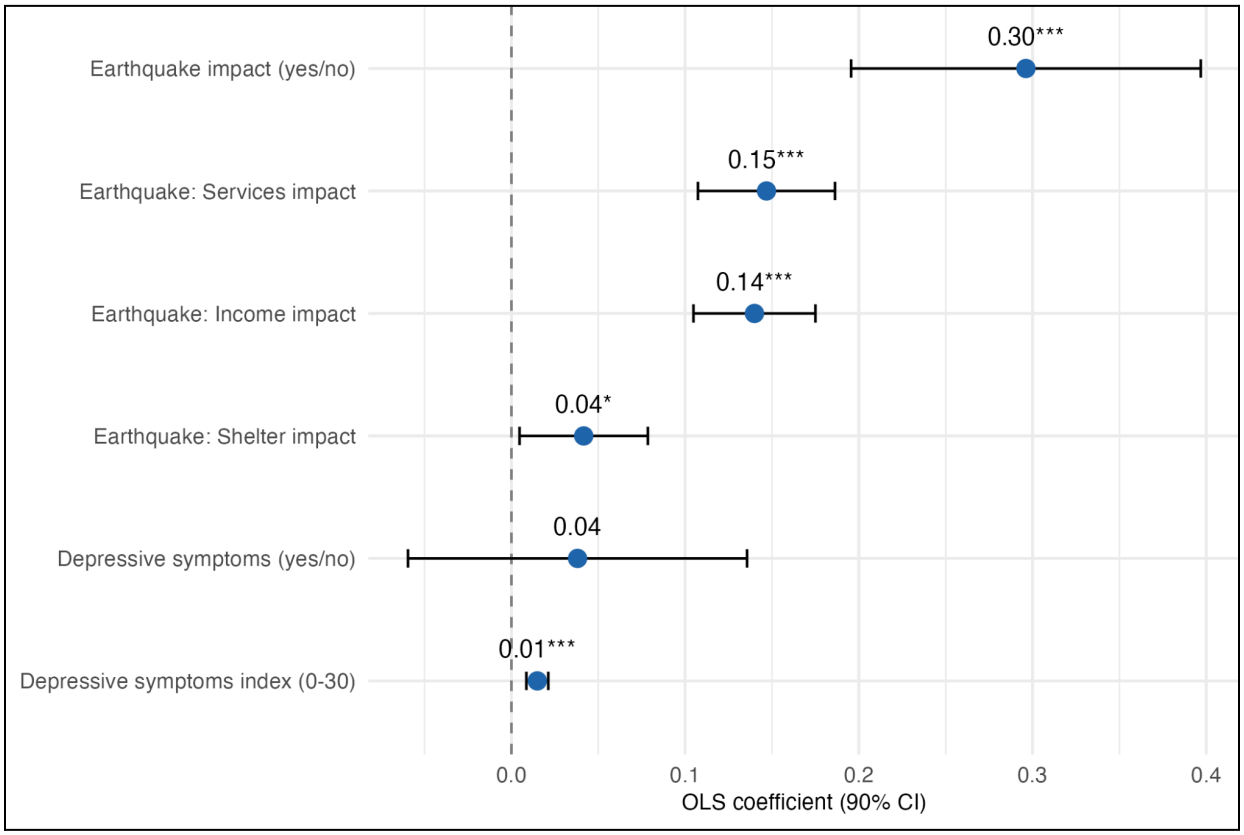


Note: *The outcome, student depressive symptoms, is measured using the UNICEF MMAP tool, which aggregates responses to 4 questions on students' depressive symptoms in the past 2 weeks (never, sometimes, often, always), The resulting aggregate outcome ranges from 0 to 12. Job satisfaction is measured as "How satisfied are you with your job", ranging from 0 to 10. Positive reciprocity captures agreement to the statement "When someone does me a favor I am willing to return it", from 1 to 5, with higher values indicating higher agreement. Teacher depressive symptoms are measured using the CES-D-10 scale, ranging from 0 to 30, with higher scores reflecting greater symptom severity.* = p < 0.1, ** = p < .05, *** = p < .01.*

4.4 Social cohesion

To better understand how households cope with and respond to shocks, Figure 26 examines the relationship between earthquake-related impacts and social networks. In particular, we assess whether households affected by the earthquake report different levels of social connectedness than those that were not affected. In terms of social cohesion, Figure 26 studies how social networks differ between households affected by the earthquake and those that were not, measured using a standardized Principal Component Analysis (PCA) index of social connections outside the household. The results reveal an interesting pattern: earthquake exposure is positively and significantly associated with stronger social networks across all dimensions.

Figure 26. Earthquake experience, mental well-being, and their role in social networks



Note: *The outcome is a standardised social network index (PCA of five binary indicators of whether the respondent knows someone outside the household who could help with housing repairs, financial lending, temporary shelter, medical advice, and childcare; higher scores reflect stronger networks). Earthquake impact variables are binary indicators of general and domain-specific earthquake exposure (shelter, income, services). Depressive symptoms are measured using the CES-D-10 scale (0–30; scores above 10 indicate clinically relevant symptoms). * p<0.1, ** p<0.05, *** p<0.01.*

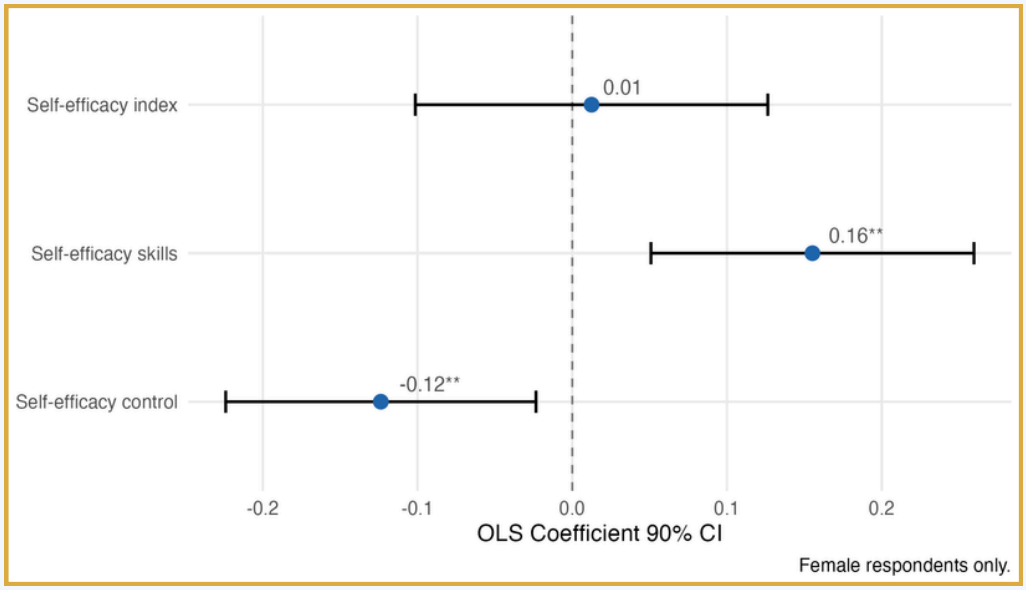
Households reporting a general earthquake impact score 0.30 standard deviations higher on the social network index ($p<0.01$), while income disruption (0.14, $p<0.01$) and service disruption (0.15, $p<0.01$) show similarly positive associations. Shelter damage shows a smaller but still significant positive effect (0.04, $p<0.1$). Households affected by the earthquake may be more likely to activate or become aware of their social networks in response to the crisis.

A similar picture emerges when looking at the role of individual well-being for social networks. To examine whether respondents reporting symptoms of depression tend to be more socially isolated, we analyze the association between symptoms of depression and social networks. For both binary and score measures of depressive symptoms, we find that more depressive symptoms are associated with having a stronger social network. The association is statistically significant for the score measure (0.01, $p<0.01$). These findings suggest that respondents experiencing symptoms of depression are not socially isolated and appear to have informal social networks they can rely on, which is consistent with the previous finding documenting strengthened social cohesion in this fragile situation.

Spotlight Livelihoods: Economic empowerment as drivers of social networks

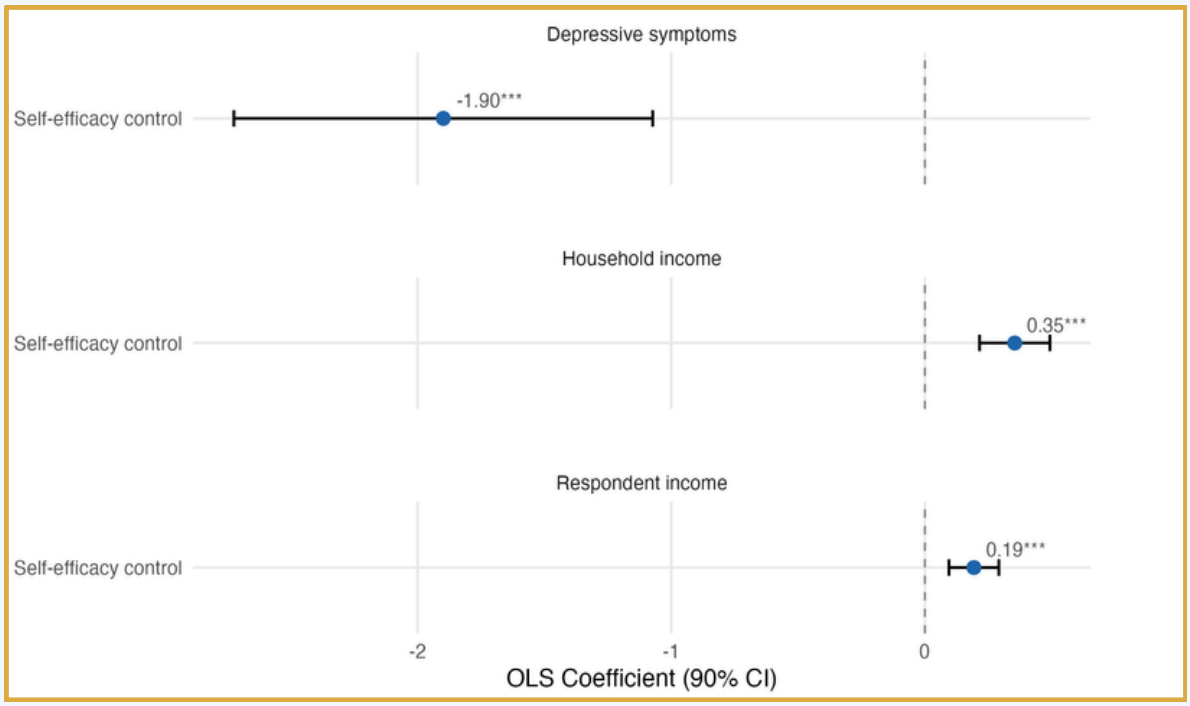
Figure 27 examines the relationship between self-efficacy and social network strength among female *livelihood* beneficiaries. The overall generalized livelihoods self-efficacy index shows no significant association with the strength of social networks. Yet, female respondents who report more confidence, skills, and support regarding income-generating activities report significantly stronger social networks (0.16, $p<0.05$). This indicates that economically active women may either accumulate broader networks through market participation, or strong social networks may function as a precursor for being able to decide on and engage in income-generating activities. For female respondents who feel they have control over economic decision-making and can pursue the kind of work they want, this points in the opposite direction (-0.12, $p<0.05$): female respondents who feel more in control of their own economic trajectories report, on average, weaker social networks. This suggests that while skills may integrate female respondents into stronger networks, high autonomy may either introduce backlash within traditional community structures or reflect a female respondents' shift toward self-reliance that reduces their dependence on informal safety nets.

Figure 27. Economic empowerment as a driver for social networks



Note: *The outcome variable is a social cohesion index (standardised), constructed using a PCA of five binary indicators measuring whether the respondent knows someone outside the household who could help with: repairing the house, lending a large sum of money, providing temporary shelter, giving medical advice, and taking care of children. Higher scores reflect stronger social networks. The generalized livelihoods self-efficacy index measures dimensions of economic empowerment, particularly regarding control and skills. Scale from "Completely agree", "Mostly agree", "Neither agree nor disagree", "Mostly disagree", to "Completely disagree". These models only include female respondents.*

Figure 28. Association between self-efficacy control, depressive symptoms, and economic outcomes



Note: Each estimate is derived from a separate ordinary least squares (OLS) regression model, allowing coefficients to be interpreted as average changes in the index associated with a one-unit change in the explanatory variable. The outcome variable changes, it is depressive symptoms in the first, household income in the second and respondent income in the third panel. The predictor is generalized livelihoods self-efficacy control. These models only include female respondents.

To assess whether the negative association between self-reported economic control and social networks reflects a potential backlash dynamic, we examine whether self-efficacy control is associated with worse economic and mental health outcomes among female respondents. The results do not support this interpretation. On the contrary, female respondents who report greater control over their economic trajectories report significantly lower depressive symptoms (-1.95, $p<0.01$) and higher household and individual income (0.35, $p<0.01$ and 0.19, $p<0.01$, respectively).

Thus, this pattern suggests that the negative association with social networks may more plausibly explained by a shift toward self-reliance: Rather than indicating social exclusion, weaker network ties among female respondents with higher perceived control over their economic trajectories may reflect a form of economic independence where female respondents may have less need for community-based safety nets. We will seek to inspect and understand this pattern further, in collaboration with GIZ and local partners.

5 Conclusions and lessons learned

Against the backdrop of two severe earthquakes in 2023, the regional project "Crisis Response in Earthquake-Affected Areas in Syria and Türkiye" (CREA) provides holistic multisectoral support to strengthen the resilience of the population residing in earthquake-affected areas to better respond to future shocks, with a particular focus on women and girls. The project provides interventions in the *education*, *health*, *livelihood*, and the *disaster risk reduction/management* sectors in the Aleppo, Idleb, Lattakia, and Hama governorates in Syria.

The baseline findings for the CREA program emphasize the widespread structural vulnerability and stressors facing people in northwest Syria. Over 77% of the surveyed population were directly affected by the 2023 earthquakes, experiencing acute impacts such as shelter damage (24%), service disruption (23%), and direct income loss (17%), compounding the high fragility after years of armed conflict. Most households currently live on an average monthly income of 2.3 million SYP, which is just barely above the subsistence threshold (Minimum Expenditure Basket, 2.2 million SYP). This economic precariousness is further exacerbated by limited income diversification, which can be a way of reducing risks and vulnerability; households rely on an average of 1.1 income sources, with 41% of the sample dependent on public sector salaries.

Despite these challenges, the findings document that institutional trust toward education and health systems remains intact. Trust in education and healthcare systems remains relatively high (averaging 2.9 and 3 out of 4, respectively). This suggests a strong social contract where the utilization of services remains high: 94% of enrolled children attend school regularly, and 86% of households sought medical advice the last time it was needed. These institutional links across sectors underline the relevance and importance of CREA program's multisectoral intervention approach.

However, the baseline results clearly demonstrate that resilience is currently undermined by significant supply-side deficiencies, as many face challenges to well-being. Perceived education quality is moderate on average (3.23 out of 5) and low ratings are strongly associated with structural issues in schools. For example, 75% of caregivers report a lack of school materials, 50% report a lack of hygienic facilities, and 48% report frequent teacher absence. In the *health* sector, quality ratings for affordability are particularly low (2.6 out of 5).

Mental well-being emerges as a critical factor that transcends the entire program; 64% of all respondents report depressive symptoms, with rates rising to 78.2% among *health* patients and 67.6% among *livelihood* respondents. Of the factors examined, earthquake

exposure is the one most strongly associated with psychological distress, emphasizing the additional threats to well-being the earthquake has created.

Ultimately, the baseline findings reinforce CREA's logic: Strengthening resilience in this context requires a holistic approach that addresses the interconnected needs of health, education, and economic security while setting a primary focus on the psychosocial well-being of the population.

The descriptive and analytical findings suggest several key lessons to guide program implementation and establish a benchmark for measuring its impact:

Lesson 1 - Supply-side quality of services undermines utilization and trust: In both the education and health sectors, specific deficiencies, such as teacher absence, lack of school materials, poor hygiene facilities, and insufficient medical consultation time, are strongly associated with lower satisfaction and utilization. Addressing these fundamental service delivery gaps is likely an effective way to improve household satisfaction and engagement in these systems.

Lesson 2 - Intersectionality shapes service accessibility and trust: In the *health* sector, accessibility challenges are not uniform across groups. For example, male respondents with disabilities reported higher accessibility deficits for general health services than female respondents with disabilities, while the overall gender gap in health access remained pronounced. Beyond physical access, households that include members with disabilities consistently report lower income levels and lower trust in both the education and health systems, signaling an intersectional vulnerability that transcends individual sectors. These findings suggest that families facing these combined challenges are more likely to have poor experiences with public services more broadly. Interventions tailored to these specific intersections of gender and disability may be better equipped to ensure equitable service delivery and rebuild trust.

Lesson 3 - Structural barriers to individual income persist for women despite financial inclusion: While improving access to financial services holds promise for strengthening household income for women, it does not significantly close the individual gender gap in earnings. This suggests that *livelihood* programs could go beyond providing capital and look deeper into the structural barriers, such as market access and social norms, that limit women's individual economic returns.

Lessons 4 - Strengthening psychosocial well-being holds enormous potential: Findings from the *education* sector suggest a powerful multiplier at the heart of the program's logic: schools with teachers experiencing higher distress and lower positive reciprocity also

have students who report more depressive symptoms. Consequently, investing in the mental well-being of teachers can not only improve well-being at the individual level, but also indirectly improve well-being for students. This validates the program's theory of change, which suggests that alleviating the psychological distress of teachers is a foundational first step that enables them to foster more nurturing classroom environments. Additionally, the data show that teachers who integrate stress management strategies into their routines report significantly lower levels of depressive symptoms. This indicates that MHPSS-centered support can be a powerful tool to strengthen professional resilience. Integrating psychosocial support as a cross-cutting foundation, rather than a sector-specific add-on may enhance program efficacy across sectors.

Lesson 5 - Crises can activate and strengthen social networks: Households affected by the earthquake report stronger social networks than those unaffected, potentially reflecting an activation of informal support systems in response to acute shocks, which appears to remain strong more than two years after the shock. CREA's programmatic efforts that aim to sustain and formalize such networks, such as engaging *livelihood* beneficiaries in VSLAs, group-based peer learning, or peer-to-peer support circles and teacher-parent associations as part of the *education* interventions, may allow it to move beyond crisis-response toward long-term community resilience.

Appendix

A1 Intervention details

CREA Intervention in the *education* sector

The *education* interventions are implemented across 17 schools in the governorates of Aleppo, Idleb, and Lattakia, reaching approximately 600 teachers and 12,500 students. Four schools with rehabilitation needs receive a construction package to restore damaged infrastructure, focusing on overall building safety, classroom size, access to natural light and fresh air, sanitary facilities, reliable electricity supply, and equipped specialized rooms such as computer labs. The interventions are implemented by two partners, Orange Organization and War Child Alliance, in cooperation with their local partner, Violet.

Orange Organization implements the intervention across eight schools hosting around 6,000 students in Aleppo and Lattakia. The intervention focuses on strengthening teacher well-being, gender empowerment, and community engagement through integrated well-being support and education activities. Around 300 teachers receive mentoring and coaching delivered both individually and in group settings, with a strong emphasis on emotional resilience, trauma-informed practices, and the empowerment of female educators. Training covers well-being in emergencies, safe identification and referral mechanisms, Psychological First Aid (PFA), and gender-responsive approaches, complemented by teacher well-being days, peer-to-peer support circles, self-care planning, supervision programs, and the distribution of teaching and learning materials. To strengthen school-community links, Parent-Teacher Associations (PTAs) are established in each of the eight schools, each engaging five men and five women who meet monthly to discuss education processes and support children's learning outcomes.

War Child Alliance, in cooperation with local partner Violet, implements a capacity development program across nine schools hosting around 7,000 students in Aleppo and Idleb. Around 300 teachers are trained on mental health and psychosocial support using the CORE methodology (Coaching, Observing, Reflecting, and Engaging). The approach combines workshop-based learning with sustained in-school coaching, beginning with five well-being workshops over the first three weeks, followed by six two-week coaching cycles. Training modules cover stress management and positive decision-making, self-care and respectful engagement, emotion regulation and self-confidence, conflict resolution and relationship building, reflective practice and self-belief, and goal setting. The intervention places particular emphasis on empowering female educators and fostering emotionally supportive learning environments.

Both interventions share the overarching objective of bolstering teachers' professional resilience and enhancing the quality of education by improving pedagogical skills, mental well-being, and motivation. In turn, empowered teachers are expected to foster inclusive, supportive classroom environments that improve student engagement, emotional well-being, and learning outcomes. The professional development intervention is rolled out throughout the 2025/26 school year, between December 2025 and June 2026.

CREA interventions in the *livelihood* sector

The *livelihood* interventions are designed to enhance economic opportunities and financial inclusion for earthquake-affected households, with a strong focus on female-headed and other vulnerable households. Three implementing partners deliver programs ranging from village savings and loan associations to digital bootcamps and loan disbursements, collectively reaching approximately 750 direct beneficiaries in Aleppo and Lattakia. All interventions share a focus on assisting participants to overcome structural barriers to economic participation by equipping them with practical skills, mentorship, financial literacy, and access to capital or employment. Programs generally launch in autumn/winter 2025 and are scheduled to conclude by autumn 2026.

Eastern Mediterranean Institute (EMI) implements a community-based economic empowerment intervention in Aleppo centered on the establishment of Village Savings and Loan Associations (VSLAs), directly benefiting 160 individuals. The intervention forms four VSLA groups of 25 participants each, drawing from two categories: 50 men and women who are graduates of a prior TVET program (woodcraft, PVC, joinery, and electricity), and 50 newly selected female participants (textile and food processing). The intervention is delivered in three phases: a community assessment and mapping exercise, the formal establishment of VSLA groups with training on financial literacy, group governance, and savings and lending mechanisms, and ongoing support facilitating access to microfinance opportunities. Additionally, 60 men and women receive specialized training on solar power system installation and maintenance alongside participation in two VSLA groups in Aleppo and Hama. Beneficiaries are prioritized based on criteria including residence in the target area, engagement in livelihood activities, female-headed households or households without a primary breadwinner, limited household assets, and a monthly income below USD 300. The intervention runs from September 2025 to August 2026.

Near East Foundation (NEF) supports the economic empowerment of 200 women entrepreneurs in Azaz and the surrounding areas of Aleppo through a comprehensive microfinance and business development intervention. Following an expression of interest

and credit screening process, women-owned businesses receive microloans ranging from EUR 400 to 1,200 and development loans between EUR 1,201 and 3,000, with flexible repayment periods of up to 30 months. Post-financing support includes tailored business site visits, group-based peer learning and exchange sessions, and on-demand follow-up support through NEF centers. Beneficiaries are selected based on residence in the target area, age between 18 and 60, ownership of an existing business or a clear business idea, and commitment to attend all training sessions and apply technical skills. The intervention runs from January to September 2026.

Syrian Forum (SF) implements an integrated entrepreneurship and employability intervention targeting 391 beneficiaries: 150 women and 150 men, plus additional participants, across Aleppo and Lattakia. The intervention consists of two tracks: entrepreneurship bootcamps providing tailored mentorship, access to resources, networking opportunities, and linkages to employment or startup support; and specialized skills bootcamps focused on high-demand digital skills including digital marketing, UI/UX design, e-commerce, no-code development, and business support. The intervention predominantly targets young adults aged 18 to 35, university graduates, and female-headed households. A subset of trained participants is connected to remote work opportunities, supported in launching or scaling small businesses, or assisted in accessing formal employment. Implementation runs from October 2025 to November 2026.

CREA interventions in the *health* sector

The *health* interventions are designed to improve equity, access, and quality of health services in Aleppo, Idleb, and Hama, with a particular focus on people with disabilities, women, girls, and other marginalized groups. Two implementing partners combine capacity-building activities with infrastructure rehabilitation, service mapping, and direct medical service provision, collectively reaching over 2,920 direct beneficiaries and approximately 25,000 patients per year, with outreach activities expected to reach around 32,000 people and indirect benefits extending to over one million individuals. Both interventions run from September 2025 to autumn 2026.

Humanity and Inclusion (HI) implements a multi-faceted intervention in Aleppo and Hama aimed at improving functional mobility and independence for people with disabilities and other functional limitations. The intervention combines the training of 46 healthcare professionals in evidence-based and inclusive rehabilitation techniques with the rehabilitation and equipping of one specialized health care center at Hama National Hospital, which currently serves around 1,000 beneficiaries per month. Through mobile units and fixed service points, a wide range of rehabilitation services are provided, including physical therapy, mobility aids, prosthetic services (108 beneficiaries), and

individual MHPSS counselling (450 individuals). A total of 2,470 individuals with physical disabilities, traumatic injuries such as war-related amputations and spinal cord injuries, and chronic conditions receive direct rehabilitation services. In addition, 1,350 caregivers receive informative sessions on the availability of local rehabilitation and mental health services, the rights of people with disabilities, and how to identify and counteract discriminatory practices. A structured service mapping exercise complemented by community awareness activities ensures that people with functional limitations can be identified and referred early to appropriate care, with 560 individuals supported through referral pathways.

Médecins du Monde (MdM) restores and strengthens three Primary Health Care Centers (PHCCs) in earthquake-affected areas of Aleppo and Idleb. The intervention includes rapid assessments of PHCCs to identify rehabilitation priorities, followed by light repairs covering hand-washing facilities, MHPSS rooms, painting, and power supply systems, alongside the provision of essential medical devices and supplies. The three centers are expected to treat approximately 25,000 patients per year, with outreach activities conducted by trained Community Health Volunteers reaching an estimated 32,000 people and indirect benefits projected to reach nearly 989,000 individuals. A total of 39 health care workers and 12 community volunteers received targeted capacity development, including training on mental health, psychosocial support, and safe referral pathways for mental health and gender-based violence cases. At the community level, tailored health communication materials are developed and disseminated in local languages, and a community feedback mechanism is established to capture concerns and suggestions from service users.

A2 Survey modules and data collection

Table A1. Definition of variables

Variable[21]	*Assessment*	*Method of scaling*
Displacement status	During the past 5 years, which of the following best describes your living situation? • I have always lived in this neighbourhood. • I moved to this neighbourhood by choice (for work, family, etc.). • I am currently displaced from another area within Syria. • I was displaced but have since returned to this neighbourhood.	Discrete: • Resident • IDP • Returnee
Earthquake impact	Regarding the 2023 earthquake: • How much was your house/shelter negatively affected? • How would you rate the level of impact on your income? • How would you rate the level of impact to your access to basic services (water, electricity, health infrastructure, education, etc.)?	Discrete: • No impact • Little impact • Moderate impact • High impact • Very high impact
Affected by earthquake	Based on the 3 previous earthquake impact indicators	Binary indicator
Access to electricity	Based on "What is your household's main source of drinking water?"	Binary indicator
Access to water	Based on "What is your household's main source of electricity?"	Binary indicator
Livelihood–Access to financial services	Does your household have access to financial services (bank account, mobile money, microcredit, savings groups)?	Binary indicator
Livelihood–Use financial services	Have you used loans, credit, or other financial services in the past 6 months (including informal credit)?	Binary indicator
Children's school attendance	Do all the enrolled children in your household attend school on a regular basis?	Binary indicator
Education quality ratings	Overall, how satisfied are you with: • The quality of education at the child's school?	0–5 Likert

[21] Cells highlighted in blue represent variables collected specifically for one sector and not available across the full sample.

	• The functionality of the child's school, i.e. the facilities, classrooms, bathrooms? • The classroom environment at the child's school in terms of safety?	
School problems	In the past school semester, did he or she experience any of the following problems? • Problems with their teacher (e.g., teacher is impatient, angry, or unfair) • Teacher absence (e.g., teacher does not come to class) • Problems with other students (e.g., being harassed by other students) • Class disruptions by other students (e.g., loud, disruptive behavior of other students during class) • Problems with class size (e.g., too many students in one class) • Lack of proper hygienic facilities (e.g., toilets) • Lack of school materials (e.g., pens, notebooks, school books)	Binary indicator
Utilization of medical services	The last time you (or a member of your household) was sick or injured, did you/they visit a doctor or seek medical help?	Binary indicator
Health– Accessibility of health services	How accessible were health services to you in the past six months?	1–10 Likert scale
Health quality ratings	For your last visit to a hospital or healthcare center, please rate each of the following items: • The doctor/nurse spent enough time during the consultation • The costs for healthcare/treatment services were affordable • The healthcare facilities were clean, functional and in good condition • It was easy to get to the place where I (or a member of my household) received medical treatment	0–5 Likert scale
Household and respondent income	In the past 30 days, what was the total (household/respondent) income (in SYP in millions) including all sources?	Continuous variable
Respondent contribution to household income	In the past 30 days, how much of the household income did you, personally, contribute (in SYP in millions)?	Proportion

Income sources	From which of these income sources did your household generate income in the past 30 days? ● Specialized labor (crafts, construction, carpentry, mechanics, tailoring, etc.) ● General labor (daily wage, agricultural wage work, porter, casual jobs) ● Small business (shops, small enterprises, transport, services) ● Public sector salary (government employment, including teachers/administration) ● Pensions / Social security ● Agriculture / Crop production ● Animal breeding / Livestock ● Remittances (money sent from abroad or other areas) ● Rental income (housing, land, assets) ● Humanitarian assistance (cash, vouchers, in-kind aid)	Count of sources
Depressive symptoms	Indicate how often you have felt this way during the past week. You can select one option from "Rarely or none of the time (less than 1 day)", "Some or a little of the time (1-2 days)", "Occasionally or a moderate amount of time (3-4 days)", "Most of the time (5-7 days)". ● I was bothered by things that usually don't bother me ● I had trouble keeping my mind on what I was doing ● I felt depressed ● I felt that everything I did was an effort ● I felt hopeful about the future ● I felt fearful ● My sleep was restless ● I was happy ● I felt lonely ● I could not "get going"	The CES-D-10 scale is used to aggregate the 10 responses. The resulting index ranges from 0 to 30, with scores above 10 used as the clinical cutoff to indicate the prevalence of depressive symptoms. Higher scores reflect greater symptom severity.
Social networks	In case something unexpected happened, do you know anyone outside your household who could help you on short notice with any of the following? ● Repair the house ● Lend you a large sum of money (6 million SYP) ● Provide a place to stay if you have to leave your house temporarily ● Give medical advice ● Take care of your children	The social cohesion index is constructed using a PCA of the 5 binary indicators. Higher scores reflect stronger social networks.

Trust	How much do you currently trust the following people and organizations? • Your extended family (outside of your household) • Your neighbors and community members • Educators and Educational institutions in your region • Doctors and health care providers	Discreet indicator: • Trust completely • Trust somewhat • Do not trust very much • Do not trust at all
Students–belief-in-self	Self-efficacy • I can work out my problems. • I can do most things if I try. • There are many things that I do well. Self-awareness • There is a purpose to my life. • I understand my moods and feelings. • I understand why I do what I do. Persistence • When I do NOT understand something, I ask the teacher again and again until I understand it. • I try to answer all the questions asked in class. • When I try to solve a math problem, I will not stop until I find the solution. Question answer ranging from (0) Not at all true of me, (1) A little true of me, (2) Pretty much true of me, Very much true of me (3)	Additive indicator that ranges from 0 to 27 (allowing for max. 1 missing item in the sub-indices). Higher values reflect more belief-in-self.
Students–emotional competence	Emotional regulation • I accept responsibility for my actions. • When I make a mistake I admit it. • I can deal with being told no. Empathy • I feel bad when someone gets his or her feelings hurt. • I try to understand what other people go through. • I try to understand how other people feel and think. Self-control • I can wait for what I want. • I don't bother others when they are busy. • I think before I act.	Discrete: • Not at all true of me • A little true of me • Pretty much true of me • Very much true of me
Students–symptoms of depression	How often you have been bothered by different problems during the past two weeks**.** • Have you felt down or very sad? • Have you felt easily annoyed or irritable at small things? Have you not enjoyed doing things you used to enjoy (like playing sports, singing and	Discrete: • Never • Sometime • Often • Always

	dancing, spending time with friends, watching videos)? • Have you felt hopeful about the future?	
Students–symptoms of anxiety	How often you have been bothered by different problems **during the past two weeks.** • Have you felt worried, nervous, or anxious? • Have you worried you can't do anything right or you were doing things incorrectly? • Have you worried about what others think of you? • Have you worried something bad will happen to you or your family? • Have you worried too much? • Have you felt unable to stop or control your worries?	Discrete: • Never • Sometime • Often • Always
Teachers–Job satisfaction	How satisfied are you with your job?	0 -10, Likert, higher values reflect more satisfaction.
Teachers–Teaching efficacy: dealing with challenging students	Indicate to which degree you agree with the following statement: "If I try really hard, I can get through to even the students with the most challenging behavior."	Discrete: • Completely agree • Mostly agree • Neither agree nor disagree • Mostly disagree • Completely disagree
Teachers–Positive reciprocity	Indicate to which degree you agree with the following statement: "When someone does me a favor I am willing to return it"	Discrete: • Completely agree • Mostly agree • Neither agree nor disagree • Mostly disagree • Completely disagree
Teachers–Use of stress strategies	Do you currently have any personal strategies to take care of your own well-being, for example through activities, habits, or support systems you use to mitigate stress?	Binary indicator
Livelihood–Self-efficacy skills	Indicate to which degree you agree with the following statements: • I am able to work outside the home if I want to.	Discrete: • Completely agree

	• I am free to pursue the types of work that interest me. • I am able to adjust my daily work schedule whenever I need to. • I am able to decide how household resources are used to pursue economic activities. • I am able to make decisions to improve my own economic wellbeing.	• Mostly agree • Neither agree nor disagree • Mostly disagree • Completely disagree
Livelihood–Self-efficacy control	Indicate to which degree you agree with the following statements: • I have the skills I need to engage in income-generating activities. • I have the social support I need to engage in income-generating activities. • I have the financial support I need to engage in income-generating activities. • I am able to find the information I need to make good decisions for my income-generating activities. • I have the confidence I need to succeed in my income-generating activities.	Discrete: • Completely agree • Mostly agree • Neither agree nor disagree • Mostly disagree • Completely disagree
Livelihood–Self-efficacy index	Based on the 10 self-efficacy items	Mean index of 10 self-efficacy items. Higher values indicate greater self-efficacy.

Figure A1. Timetable of baseline data collection

	2025				2026				
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Education									
Orange									
Warchild									
Livelihood									
EMI									
SF									
NEF									
Health									
MdM									
Hi									

A3 Additional descriptive results

Table A2. Respondent and household profile by CREA partner

	Education		*Health*		*Livelihood*		
	Orange	*Warchild*	*MdM*	*HI*	*EMI*	*NEF*	*SF*
n	278	195	302	273	154	567	194
Respondent profile							
Female (%)	80.2	97.4	80.1	38.8	68.2	100.0	61.3
Age in years	43.0 (7.4)	35.4 (7.2)	36.5 (13.3)	46.4 (18.0)	33.8 (11.3)	37.4 (9.8)	24.9 (7.8)
Education level (%)*							
None or Primary	0.4	0.0	75.7	-	32.5	82.4	0.5
Secondary	3.6	0.5	13.4	-	26.6	8.5	15.5
Tertiary	96.0	99.5	10.8	-	40.9	9.2	84.0
Income (million SYP)	1.4 (0.5)	1.4 (0.4)	0.7 (1.3)	1.3 (1.1)	1.1 (1.0)	1.0 (1.0)	0.5 (0.9)
Married (%)	75.2	76.9	92.4	0.0	46.8	46.7	11.3
Disability (%)	-	-	6.0	92.7	-	-	-
Household profile							
Female HHH (%)	32.7	12.8	12.6	10.6	53.9	57.5	15.5
Age of HHH	48.4 (10.8)	44.6 (11.2)	40.9 (13.2)	50.3 (16.5)	36.6 (14.1)	38.2 (10.3)	51.0 (14.8)
Educational level of HHH							
None or Primary	10.5	15.0	77.5	78.6	37.7	83.2	24.0
Secondary	10.9	18.1	10.6	5.6	24.7	6.7	20.8
Tertiary	78.7	66.8	11.9	15.9	37.7	10.1	55.2
Income HH	2.6 (1.2)	2.4 (1.3)	2.1 (1.9)	1.7 (1.3)	1.9 (1.6)	2.0 (1.3)	3.4 (1.6)
Number of HH members	4.1 (1.9)	4.8 (2.0)	5.0 (2.3)	5.4 (3.3)	5.3 (2.1)	5.6 (2.1)	5.1 (2.0)
Number of children in HH	1.6 (1.4)	2.4 (1.7)	2.6 (2.0)	2.0 (2.2)	1.6 (1.6)	3.2 (1.8)	1.2 (1.4)
A HH member with disability (%)*	20.5	16.6	34.9	100.0	46.8	35.4	20.1
Governorate							
Aleppo	44.2	43.1	41.7	98.9	100.0	100.0	69.1
Lattakia	55.4	0.0	0.0	0.0	0.0	0.0	30.9
Idleb	0.4	56.9	58.3	1.1	0.0	0.0	0.0
Urban area (%)	86.3	29.7	0.7	88.6	99.4	54.0	95.4
Displacement status (%)							
Resident	88.8	90.8	65.8	94.9	59.3	54.0	76.8

IDP	5.4	8.2	17.9	3.7	21.3	44.8	15.5
Returnee	5.8	1.0	16.3	1.5	19.3	1.2	7.7
Affected by earthquake (%)	78.4	63.1	74.2	72.2	75.3	80.6	93.3

Note: Means and standard deviations (in parentheses) are reported for continuous variables, and percentages for categorical variables. Missing values are excluded from all calculations. * *= Variable not collected for HI.*

Table A3. Key baseline outcomes indicators by CREA partner

	Education		*Health*		*Livelihood*		
	Orange	*Warchild*	*MdM*	*HI*	*EMI*	*NEF*	*SF*
Access to basic and financial services							
Access to national electric grid (%)	84.9	93.8	45.0	58.2	68.8	93.7	94.8
Access to running water at home (%)	93.2	74.9	36.4	78.8	98.7	46.4	69.1
Access to financial services (%)	-	-	-	-	57.5	3.9	58.3
Use of financial services (%)	-	-	-	-	30.7	0.7	9.3
Access to and quality of education services							
Attendance of enrolled children (%)	95.8	99.3	83.9	91.8	87.9	98.2	91.5
Quality: Environment (0-5)	3.6 (1.0)	3.8 (0.8)	3.4 (1.0)	3.2 (1.0)	3.0 (0.9)	3.1 (1.0)	3.7 (1.0)
Quality: Functionality (0-5)	3.3 (1.1)	3.6 (0.8)	2.9 (1.1)	2.9 (1.0)	2.9 (1.0)	3.1 (0.9)	3.3 (1.0)
Quality: Overall satisfaction (0-5)	3.6 (1.1)	3.8 (0.8)	3.3 (1.1)	3.1 (1.1)	3.0 (0.9)	3.0 (1.0)	3.4 (1.2)
Access to and quality of health services							
Seek health services when needed (%)	73.8	92.8	80.4	79.4	63.4	99.5	94.3
Accessibility of health services (1-10)	-	-	4.9 (2.3)	4.2 (2.3)	-	-	-
Quality: Accessibility (0-5)	3.2 (1.4)	3.6 (0.9)	2.8 (1.3)	2.6 (1.3)	2.9 (1.1)	3.2 (0.8)	3.8 (1.2)
Quality: Affordability (0-5)	2.5 (1.6)	2.9 (1.0)	2.1 (1.1)	2.2 (1.3)	2.5 (1.1)	2.8 (0.9)	2.9 (1.2)
Quality: Functionality (0-5)	3.1 (1.4)	3.4 (0.9)	3.4 (1.0)	2.7 (1.2)	2.5 (1.0)	3.5 (0.7)	3.6 (1.2)
Quality: Time (0-5)	3.3 (1.4)	3.6 (1.0)	3.7 (1.1)	3.3 (1.2)	3.4 (1.0)	3.1 (0.9)	3.8 (1.2)
Income, mental wellbeing and social cohesion							
Monthly income HH (in million SYP)[22]	2.6 (1.2)	2.4 (1.3)	2.1 (1.9)	1.7 (1.3)	1.9 (1.6)	2.0 (1.3)	3.4 (1.6)

[22] All monetary values are in the old SYP currency prior to the early 2026 redenomination.

Monthly income respondent	1.4	1.4	0.7	1.3	1.1	1.0	0.5
	(0.5)	(0.4)	(1.3)	(1.1)	(1.0)	(1.0)	(0.9)
Average # of income sources	2.6	2.4	2.1	1.7	1.9	2.0	3.4
	(1.2)	(1.3)	(1.9)	(1.3)	(1.6)	(1.3)	(1.6)
Index for depressive symptoms (0-30)	1.4	1.4	0.7	1.3	1.1	1.0	0.5
	(0.5)	(0.4)	(1.3)	(1.1)	(1.0)	(1.0)	(0.9)
Social network index	1.4	1.3	1.0	0.3	1.6	1.1	1.1
	(0.6)	(0.5)	(0.3)	(0.4)	(0.6)	(0.3)	(0.6)
Trust in education systems (1-4)	9.9	8.3	16.0	14.3	18.4	14.6	8.9
	(6.0)	(5.4)	(6.9)	(6.5)	(5.4)	(8.5)	(5.7)
Trust in health systems (1-4)	0.1	-0.5	-0.5	-0.4	0.3	0.2	0.3
	(0.9)	(0.9)	(0.9)	(1.0)	(1.0)	(1.0)	(0.8)

Note: Means and standard deviations (in parentheses) are reported for continuous variables, and percentages for categorical variables. Missing values are excluded from all calculations. * *= Variable not collected for HI.*

giz Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH

ISDC INTERNATIONAL SECURITY AND DEVELOPMENT CENTER